DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201

FOIA Request 2019-0433

Freedom of Information Act Office
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Washington DC 20201

July 30, 2019

Donald Triplett, III
MuckRock News
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Dear Mr. Triplett:

This is in response to the March 18, 2019, Freedom of Information Act (FOIA) request you submitted to the Department of Health and Human Services (HHS), Office of Inspector General (OIG), seeking a copy of the current written guidelines developed by OIG pertaining to the handling of Hotline calls and referrals. These guidelines would specifically include the two documents entitled "OIG Hotline Program Orientation" and "OIG Hotline Screening Protocols" as well as any additional guidelines the OIG may utilize.

This office located one-hundred and twenty (120) pages responsive to your request; I have determined to release all one-hundred and twenty (120) pages in full without deletion. **Please Note**: These are the most current guidelines published by the Hotline.

I trust that this information fully satisfies your request. If you need any further assistance or would like to discuss any aspect of your request, please do not hesitate to contact our FOIA Requester Service Center at 202.619.2541 or email at FOIA@oig.hhs.gov.

For your information, Congress excluded three discrete categories of law enforcement and national security records from the requirements of the FOIA. See 5 U.S.C. § 552(c) (2006 & Supp. IV (2010). This response is limited to those records that are subject to the requirements of the FOIA. This is a standard notification that is given to all our requesters and should not be taken as an indication that excluded records do, or do not, exist.

Sincerely,

Robin R. Brooks
Director
Freedom of Information

U.S. Department of Health & Human Services
Office of Inspector General

OIG HOTLINE – CONTRACTOR SCREENING PROTOCOLS

JULY 2010

FOR OFFICIAL USE ONLY
This information is intended for the internal use of the OIG Hotline staff only.

PREFACE

THE MISSION OF THE OIG HOTLINE IS TO RECORD FRAUD COMPLAINTS THAT COULD POTENTIALLY RESULT IN MONETARY RECOVERIES, CIVIL PENALTIES, OR CRIMINAL PROSECUTION.

PAST EXPERIENCE SHOWS, HOWEVER, THAT MOST OF YOUR CALLS WILL NOT INVOLVE A FRAUD ISSUE.

AS A HOTLINE REPRESENTATIVE YOU WILL SCREEN PUBLIC SUBMISSIONS ACCORDING TO THESE THREE BASIC QUESTIONS:

1) DOES THE SUBMISSION INVOLVE A PROGRAM OR INITIATIVE OF THE DEPARTMENT?

2) DOES THE SOURCE WANT TO MAKE AN ALLEGATION OF FRAUD? (AS OPPOSED TO HAVING A QUESTION OR POLICY COMPLAINT)?

3) DOES THE SOURCE HAVE ENOUGH SPECIFIC INFORMATION TO WARRANT FURTHER REVIEW?

FOR ALL COMPLAINT TYPES OUR JOB IS TO COLLECT TIPS. WHEN WE SPEAK OF A "TIP" WE GENERALLY HAVE IN MIND A HELPFUL HINT, USUALLY RELYING ON INSIDE INFORMATION. IT IS NOT MUCH OF A TIP TO SAY THAT RUSH HOUR TRAFFIC IN THE WASHINGTON AREA IS BAD; IT WOULD BE A PRETTY GOOD TIP TO KNOW AT A PARTICULAR TIME THAT I-66 WESTBOUND IS CLOSED DUE TO AN ACCIDENT. SIMILARLY, IT IS NOT MUCH OF A TIP TO SAY THAT A LOT OF DOCTORS CHEAT MEDICARE, BUT IT WOULD BE A DIFFERENT MATTER WERE A FORMER EMPLOYEE TO ALLEGE THAT A PARTICULAR DOCTOR CONSISTENTLY BILLS ROUTINE OFFICE VISITS AS EXTENDED VISITS.

ABOUT THESE INSTRUCTIONS

THESE SCREENING PROTOCOLS WILL FOCUS ON HOW TO ANALYZE CALLS TO DETERMINE THE CIRCUMSTANCES WHICH SUGGEST THAT FURTHER REVIEW MAY BE WARRANTED. THEY DO NOT PRETEND TO OFFER EXACT FORMULAS THAT CAN BE APPLIED TO EVERY SITUATION. IN OTHER WORDS, THEY WILL NOT SUBSTITUTE FOR YOUR OWN JUDGEMENT.

ASSUME THAT "TAKE A COMPLAINT," "ENTER A COMPLAINT," OR SIMILAR PHRASES REFERS TO SAVING A COMPLAINT RECORD IN YOUR COMPLAINT SYSTEM.

WHENEVER YOU ENTER A COMPLAINT, YOU ARE IN EFFECT ACCUSING SOMEONE OF A CRIME AGAINST THE FEDERAL GOVERNMENT — SO TO MAKE A CORRECT DECISION ABOUT WHETHER TO ENTER A COMPLAINT, IT IS NECESSARY THAT YOU RECEIVE UNAMBIGUOUS ANSWERS TO YOUR QUESTIONS.

EACH CHAPTER ADDRESSES THE FACTORS RELEVANT TO A SPECIFIC PROGRAM, SOURCE, OR COMPLAINT CATEGORY.

EACH CHAPTER WILL INCLUDE COMMON TYPES OF COMPLAINTS AND BACKGROUND MATERIAL TO HELP YOU ANALYZE SITUATIONS.

EACH CHAPTER WILL ALSO INCLUDE SAMPLE COMMENTS FOR THE COMPLAINT AND SOURCE TYPES DISCUSSED. USE THESE SAMPLE COMMENTS AS MODELS FOR THE AMOUNT OF DETAIL AND STYLE THAT YOU SHOULD ASPIRE TO.

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INTERVIEW BASICS

KEEPING IN MIND THAT THE QUESTIONS YOU WILL BE ASKING WILL VARY ACCORDING TO EACH SITUATION THERE ARE CERTAIN PRINCIPLES THAT WILL APPLY TO ALL TELEPHONE INTERVIEWS.

GREETING

"INSPECTOR GENERAL'S HOTLINE, MAY I HELP YOU?"

ALWAYS GREET THE CALLER COURTEOUSLY — BESIDES CONVEYING A PROFESSIONAL ATTITUDE, THIS WILL HELP YOU TO GAIN CONTROL OF THE CONVERSATION.

DEVELOPMENT

AT THE OUTSET OF THE CONVERSATION YOU WANT TO BE LISTENING RATHER THAN WRITING. IT WILL BE VERY FRUSTRATING BOTH FOR YOU AND THE CALLER IF, AFTER RECORDING EXTENSIVE DETAILED INFORMATION — ESPECIALLY FROM A CALLER WHO IS CONFUSED OR HEARING-IMPAIRED — YOU LEARN THAT THE CALLER ONLY WANTS TO ASK A QUESTION OR THAT THE ALLEGATION DOES NOT INVOLVE A HHS PROGRAM OR EMPLOYEE.

ALLOW THE CALLER TO TRY TO EXPLAIN THE SITUATION IN HIS OWN WORDS, BUT YOU SHOULD BE PREPARED TO PROMPT HIM TO STAY FOCUSED ON THE ISSUE.

THROUGH EVERY STAGE OF THE INTERVIEW, YOU WANT TO BE CONSCIOUS OF PROGRESSING FROM OPEN-ENDED QUESTIONS ("PLEASE TELL ME ABOUT THE SITUATION") TO CLOSE-ENDED QUESTIONS ("DID YOU GO TO THE EMERGENCY ROOM ON THAT

DATE?").

NATURALLY, YOU NEED TO LISTEN TO THE CALLER CAREFULLY IN ORDER TO ASK THE APPROPRIATE CLOSE-ENDED QUESTIONS.

CLOSE-ENDED QUESTIONS CAN BE YOUR BEST TOOL FOR CONTROLLING A LONG-WINDED CALLER.

DO NOT GET INVOLVED IN A DISCUSSION OVER THE DEFINITION OF FRAUD.

DECISION

AT SOME POINT IN EVERY CALL YOU WILL HAVE TO DECIDE ON WHAT WILL BE THE BEST POSSIBLE OUTCOME FOR THIS CALL.

ALTHOUGH YOU NEED TO BE TIME-CONSCIOUS IN YOUR INTERVIEWS, DO NOT RUSH TO THIS POINT: YOU SHOULD THOROUGHLY UNDERSTAND THE CALLER'S SITUATION BEFORE MAKING A DECISION.

WHILE THERE WILL BE EXCEPTIONS, EXPERIENCE HAS SHOWN THAT MOST CALLS WILL FALL INTO ONE OF THE FOLLOWING CATEGORIES:

- THE CALLER HAS A QUESTION THAT WOULD BE BEST ANSWERED BY A DIFFERENT AGENCY — EXAMPLE, A CALLER MIGHT BE SUSPICIOUS OF A CHARGE ON A MEDICARE NOTICE, BUT DOES NOT REALLY UNDERSTAND SOME TERMINOLOGY;

- THE CALLER'S ALLEGATION DOES NOT INVOLVE A HHS PROGRAM OR EMPLOYEE — EXAMPLE, A CALLER MIGHT CALL US TO REPORT THE MISCONDUCT OF AN EMPLOYEE OF THEIR **STATE** DEPARTMENT OF HEALTH AND HUMAN SERVICES;

- THE CALLER'S ALLEGATION INVOLVES A CIVIL ISSUE RATHER THAN FRAUD AGAINST THE DEPARTMENT — EXAMPLE, A CALLER MAY COMPLAIN TO OUR OFFICE ABOUT BEING DISMISSED UNFAIRLY BY A PRIVATE EMPLOYER BECAUSE THE COMPANY RECEIVES MEDICARE PAYMENTS;

- THE CALLER WANTS OIG INTERVENTION TO RESOLVE A PERSONAL PROBLEM – EXAMPLE, A CALLER MAY WANT OUR TO HELP A MEDICARE BENECIARY TO OBTAIN A POWER WHEELCHAIR;

- THE CALLER'S ALLEGATION MERITS FURTHER REVIEW AS A POSSIBLE INSTANCE OF FRAUD AGAINST THE DEPARTMENT — FOLLOW THE GUIDANCE IN THE SCREENING PROTOCOLS.

EXPLANATION

YOU WILL NEED TO EXPLAIN YOUR DECISION TO THE CALLER, WHATEVER IT IS.

YOUR EXPLANATION SHOULD CONVEY THE RELEVANCE OF THE CALLER'S SITUATION TO THE OIG MISSION.

YOUR EXPLANATION WILL BE ESPECIALLY SENSITIVE WHEN THE DECISION IS NOT TO ENTER AN ALLEGATION – SOME CALLERS WILL FEEL THAT YOU ARE NOT TAKING THEIR CONCERNS SERIOUSLY.

IT WILL HELP AVOID HURT FEELINGS IF YOU HAVE EXPLANATIONS READY FOR COMMON SITUATIONS; YOUR EXPLANATION SHOULD FOCUS ON THE OIG'S JURISDICTION. WHEN APPROPRIATE, SUGGEST AN ALTERNATIVE COURSE OF ACTION, SUCH AS CALLING ANOTHER NUMBER.

IT IS VERY IMPORTANT THAT THE CALLER CLEARLY UNDERSTANDS THE DECISION YOU MADE. THERE WILL BE INSTANCES WHERE THE

CALLER MAY RELATE A GREAT NUMBER OF DETAILS ABOUT A SITUATION BEFORE YOU DECIDE THAT HE NEEDS TO SPEAK WITH ANOTHER AGENCY. YOU SHOULD NOT LEAVE THE CALLER WITH THE IMPRESSION THAT WE ARE GOING TO TAKE ANY MORE ACTION, EVEN THOUGH HE FULLY EXPLAINED THE SITUATION.

ALLEGATION PROCESSING

IF YOU DETERMINE THAT THE CALL MEETS THE CRITERIA FOR ENTERING AN ALLEGATION, EXPLAIN TO THE CALLER THAT YOU CAN ENTER A COMPLAINT THAT WILL BE REFERRED TO THE APPROPRIATE OFFICE FOR REVIEW AND EVALUATION. OFFER TO TAKE AN ALLEGATION.

IF THE CALLER WISHES TO ENTER AN ALLEGATION, YOU SHOULD ASK HER FOR FULL INFORMATION ON THE SITUATION. YOU WILL BE ASKING DETAILED QUESTIONS AND RECORDING ALL NECESSARY INFORMATION.

SOME CALLERS MAY INDICATE A DESIRE TO MAKE A MISSION-RELEVANT COMPLAINT BUT THAT THEY ARE NOT SURE IF THEY HAVE ALL THE INFORMATION WE NEED. A FEW SIMPLE QUESTIONS SHOULD HELP YOU TO DETERMINE THIS – THE SAMPLE COMMENTS IN EACH SECTION CAN GIVE YOU AN IDEA. WHENEVER POSSIBLE, YOU SHOULD TRY TO GET TAKE THE COMPLAINT ON THE FIRST CALL, PARTICULARLY IF THE CALLER IS A HEALTH CARE EMPLOYEE OR ANOTHER HIGH-VALUE SOURCE WHO MAY HAVE LITTLE TIME OR OPPORTUNITY TO CALL BACK.

FOR EXAMPLE, IF THE CALLER CAN EXPLAIN HOW A KICK-BACK SCHEME IS ARRANGED BUT CANNOT REMEMBER THE DATE OF A CERTAIN MEETING THERE SHOULD BE NO REASON THAT YOU SHOULD NOT TAKE THE COMPLAINT.

WHENEVER YOU AND THE CALLER DECIDE THAT THE CALLER NEEDS TO GATHER SOME MORE INFORMATION BEFORE MAKING A COMPLAINT BE SURE THAT HE UNDERSTANDS THAT YOU ARE NOT

ESTABLISHING A COMPLAINT RECORD AT THAT TIME. YOU CAN PROVIDE THE CALLER YOUR OPERATING NUMBER AND SUGGEST THAT HE ASK TO BE TRANSFERRED TO YOU, BUT WARN THE CALLER THAT YOU MAY NOT BE AVAILABLE SO HE SHOULD BE PREPARED TO RE-TELL HIS SITUATION FROM THE BEGINNING.

FOR ANY COMPLAINT, YOU WILL SOLICIT THE NAME, ADDRESS, AND PHONE NUMBER FOR BOTH THE CALLER AND THE SUBJECT(S) OF THE COMPLAINT.

VERIFY THE SPELLING OF ANY UNFAMILIAR WORD.

THE INSTRUCTIONS FOR DIFFERENT TYPES OF COMPLAINTS WILL OUTLINE QUESTIONS UNIQUE TO THOSE SITUATIONS THAT YOU WILL NEED TO GATHER FOR THOSE COMPLAINTS BUT THERE ARE SOME GENERAL QUESTIONS THAT WILL BE RELEVANT TO ALMOST ANY SITUATION:

- HOW LONG HAS THE ACTIVITY TAKEN PLACE?
- HOW IS THE CALLER AWARE OF THE ACTIVITY?
- WHAT OFFICIALS WITHIN THE AGENCY/ENTITY ARE INVOLVED IN/AWARE OF THE ACTIVITY?
- HOW IS THE INDIVIDUAL/ENTITY ABLE TO CONCEAL THE ACTIVITY?
- HAS THE CALLER REPORTED THE ACTIVITY TO ANYONE ELSE?
- WHAT HAS BEEN THE IMPACT (E.G., COST) OF THE ACTIVITY?
- DOES THE CALLER HAVE ANY DOCUMENTARY EVIDENCE?

IF YOU ARE CONFUSED ABOUT ANY POINT OF THE CALLER'S EXPLANATION – HOW DIFFERENT PARTIES FIT INTO A COMPLEX SCENARIO, HOW THE SCENARIO AFFECTS A DEPARTMENT

PROGRAM/INITIATIVE – IT IS VERY IMPORTANT THAT YOU CLEAR THESE UP WHILE THE CALLER IS ON THE PHONE. WHEN ASKED TO CLARIFY A POINT MADE IN YOUR COMMENTS IT IS UNACCEPTABLE TO FALL BACK ON "THAT'S WHAT HE SAID."

DOCUMENTATION

SOME CALLERS MAY INDICATE THAT THEY HAVE DOCUMENTATION IN CONNECTION WITH THEIR COMPLAINT. THE ADDITION OF ANY WRITTEN MATERIAL WILL SLOW DOWN THE REFERRAL OF THE COMPLAINT, SO TELL THE CALLER THAT YOU WILL NOTE IN YOUR COMMENTS THAT SHE HAS ADDITIONAL INFORMATION IN HIS POSSESSION. THE PERSON IN THE FIELD WHO ULTIMATELY RECEIVES THE COMPLAINT CAN THEN MAKE THE DECISION AS TO WHETHER HE WANTS THIS INFORMATION.

THE ONLY EXCEPTION MIGHT BE IF YOUR JUDGEMENT TELLS YOU THE COMPLAINT INVOLVES A TIME-SENSITIVE MATTER FOR WHICH THE DOCUMENTATION IS ESSENTIAL.

EXIT

ALWAYS THANK THE CALLER FOR HAVING TAKEN THE EFFORT TO CALL THE INSPECTOR GENERAL'S CALL CENTER.

IF YOU HAVE INDICATED THAT YOU HAVE ENTERED A COMPLAINT YOU MIGHT ANTICIPATE QUESTIONS ABOUT WHAT WILL HAPPEN WITH THE COMPLAINT. IN RESPONSE YOU SHOULD REITERATE THAT YOU WILL ENTER THE INFORMATION INTO THE DATA BASE AND IT WILL BE REFERRED TO THE APPROPRIATE AGENCY FOR REVIEW AND DEVELOPMENT. IF THE CALLER PERSISTS, EXPLAIN THAT THIS IS THE HOTLINE'S SOLE INVOLVEMENT IN THE PROCESS AND YOU CANNOT COMMENT ANY FURTHER.

IN RESPONSE TO POINTED QUESTIONS ABOUT WHETHER THE CALLER CAN EXPECT TO HEAR ANYTHING FURTHER YOU SHOULD SAY THAT

THE HOTLINE WILL NOT BE CONTACTING HIM. ASSUMING HE PROVIDED HIS ADDRESS AND PHONE NUMBER, ADVISE THAT THE REVIEWING AGENCY MIGHT CONTACT HIM BUT YOU CANNOT GUARANTEE IF OR WHEN THAT MIGHT HAPPEN.

IF A CALLER PROTESTS THAT SHE NEEDS RESOLUTION OF HER COMPLAINT IN ORDER TO PROCEED WITH A PERSONAL ISSUE, SUCH AS A LAWSUIT, DISPUTE WITH AN EMPLOYEER, OR NOTICE FROM A COLLECTION AGENCY, EXPLAIN THAT SHE SHOULD NOT WAIT TO HEAR ANY RESPONSE ON HER COMPLAINT WITH THE HOTLINE BEFORE TAKING OTHER MEASURES TO DEAL WITH THE PERSONAL ISSUE.

COMPLAINT ENTRY

YOU WILL THEN ENTER THE DATA ACCURATELY INTO THE COMPLAINT DATA BASE, WHICH WILL ENTAIL ENTERING DATA AND CODED INFORMATION FOR THE CALLER AND SUBJECT OF THE COMPLAINT, AND EXPLAINING THE SUBSTANCE OF THE COMPLAINT IN NARRATIVE COMMENTS.

THERE MAY BE INSTANCES WHEN YOU TOLD A COMPLAINANT THAT YOU INTENDED TO ENTER A COMPLAINT BUT AFTER THE CALL YOUR BETTER JUDGEMENT TELLS YOU THAT THE ISSUE DOES NOT MERIT FURTHER REVIEW. THIS MIGHT ARISE IN INSTANCES WHERE A CALLER WAS PARTICULARLY AGGRESSIVE OR EMOTIONAL. IF YOU HAVE SECOND THOUGHTS, CHECK WITH A SENIOR ANALYST BEFORE ENTERING THE COMPLAINT. IF YOU RECEIVE INSTRUCTIONS NOT TO ENTER THE COMPLAINT YOU SHOULD RETAIN YOUR NOTES FROM THE CALL FOR FUTURE REFERENCE.

IT IS NOT ACCEPTABLE TO TELL A CALLER THAT YOU WILL ENTER A COMPLAINT WHEN YOU HAVE NO INTENTION OF DOING SO.

"DO I HAVE TO IDENTIFY MYSELF"

THERE WILL BE A STUMBLING POINT IN MANY CONVERSATIONS WHEN YOU ASK A COMPLAINANT TO IDENTIFY HIMSELF, I.E., PROVIDE HIS NAME, ADDRESS, PHONE NUMBER, POSITION TITLE.

CALLERS MAY BE PARTICULARLY RELUCTANT TO IDENTIFY THEMSELVES IF THEY ARE PROVIDING TIPS AGAINST A CURRENT OR FORMER EMPLOYER.

WE WANT CALLERS TO IDENTIFY THEMSELVES. YOU SHOULD TRY TO EXPLAIN TO EVERY CALLER WHO DOES NOT WANT TO IDENTIFY HERSELF WHY IT IS IMPORTANT: BECAUSE OUR OFFICE ONLY TAKES THE INITIAL COMPLAINT, IT WILL BE IMPORTANT FOR THE PERSON RESPONSIBLE FOR REVIEWING THE COMPLAINT TO HAVE A CONTACT POINT SHOULD HE HAVE ADDITIONAL QUESTIONS.

IN THE PAST MANY CALLERS HAVE INDICATED THAT THEY WILL REVEAL THEMSELVES ONCE THEY ARE ASSURED AN INVESTIGATION (OR AUDIT) HAS BEGUN. YOU SHOULD TELL SUCH A CALLER THAT THE ABSENCE OF COMPLAINANT INFORMATION COULD CAUSE THE COMPLAINT TO BE GIVEN A LOW PRIORITY IN THE FIELD.

IF A CALLER IS WORRIED ABOUT HER IDENTITY GETTING BACK TO HER EMPLOYER, EXPLAIN THAT HER IDENTITY SHOULD BE KEPT WITHIN LAW ENFORCEMENT CIRCLES **[BUT BE CLEAR THAT YOU CANNOT GIVE ANY GUARANTEES ON THIS ACCOUNT]**

EXPLAIN FURTHER THAT IF THE INVESTIGATION RESULTS IN ANY COURT ACTION, SUCH AS A SUBPOENA BEING ISSUED, OUR OFFICE MAY BE FORCED TO REVEAL HER IDENTITY.

FOR THOSE WHO WISH TO REMAIN ANONYMOUS TRY TO ASCERTAIN HOW THEY ARE AWARE OF THE SITUATIONS THEY ARE REPORTING.

"I CALLED / WROTE BEFORE"

YOU WILL OCCASIONALLY RECEIVE INQUIRIES FROM CALLERS WHO CLAIM THAT THEY PREVIOUSLY CALLED OR WROTE TO THE HOTLINE.

THE HOTLINE IS NOT AUTHORIZED TO RELEASE INFORMATION TO THE PUBLIC ON RECORDS WE HAVE RECEIVED.

IT SHOULD BE OBVIOUS THAT YOU CANNOT RESPOND TO INQUIRIES OF THE TYPE, "DO YOU HAVE ANY COMPLAINTS AGAINST ABC HOSPITAL?"

BUT THIS ALSO MEANS THAT YOU SHOULD NOT RESPOND TO INQUIRIES FROM CALLERS WHO CLAIM THAT THEY PREVIOUSLY CALLED OR WROTE TO THE HOTLINE. WE HAVE NO WAY OF KNOWING IF THE CALLER IS ACTUALLY THE ORIGINAL COMPLAINANT OR A THIRD PARTY TRYING TO FIND OUT WHETHER A CERTAIN INDIVIDUAL HAS FILED A COMPLAINT. YOU ARE NOT AUTHORIZED TO CONFIRM OR DENY THE EXISTENCE OF A COMPLAINT IN OUR SYSTEM OR THE RECEIPT OF A LETTER/EMAIL.

HIGH PROFILE CALLS

EVEN AS CONTRACTOR EMPLOYEES YOU ARE BEING ENTRUSTED WITH THE COLLECTION AND SAFEKEEPING OF SENSITIVE PERSONAL INFORMATION. BUT THERE ARE CERTAIN CALLS WHICH SHOULD BE REFERRED TO THE HOTLINE'S INTERNAL STAFF WHEN IDENTIFIED. THE THREE MAIN TYPES OF CALLS THAT SHOULD BE REFERRED ARE:

1) CALLS FROM OR ALLEGATIONS AGAINST HHS EMPLOYEES;

2) CALLS FROM ACTIVE LAW ENFORCEMENT PERSONNEL (EMPLOYEES OF LOCAL/STATE/FEDERAL INVESTIGATIVE OR PROSECUTORIAL AGENCIES);

3) CREDIBLE CALLS ABOUT SITUATIONS THAT COULD ATTRACT MEDIA INTEREST (E.G., A CALL FROM THE CEO OF A HOSPITAL,

NOT A ROUTINE CALL WHERE THE COMPLAINANT THREATENS TO CALL A LOCAL TV STATION).

THIS LIST WILL BE SUPPLEMENTED OCCASIONALLY IN RESPONSE TO DEPARTMENT AND OIG INVESTIGATIVE PRIORITIES AND INITIATIVES.

ANY CALL MEETING THESE CRITERIA SHOULD BE REFERRED TO **1-866-893-9622.**

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MEDICARE BENEFICIARIES

MANY OF THE CALLS, LETTERS, AND EMAILS RECEIVED AT THE HOTLINE ARE FROM MEDICARE BENEFICIARIES OR THEIR FAMILY MEMBERS WHO WANT TO DISPUTE A CHARGE TO MEDICARE THAT THEY LEARNED ABOUT FROM A MEDICARE SUMMARY NOTICE (MSN) OR FROM THEIR ON-LINE MyMEDICARE ACCOUNT. EXPERIENCE HAS SHOWN THAT THESE CALLS DO NOT OFTEN YIELD TIPS THAT LEAD TO CRIMINAL INVESTIGATIONS.

BUT SUCH CALLS PROVIDE IMPORTANT INSIGHT INTO GEOGRAPHIC AND PROGRAMMATIC TRENDS AS WELL AS IDENTIFYING OVERPAYMENTS THAT CAN BE RECOVERED.

MOREOVER, THE VOLUME OF SUCH CALLS DEMANDS THAT YOU BE PREPARED TO HANDLE THEM EFFICIENTLY.

MSN-SPECIFIC CALLS

WHENEVER A CALLER INDICATES THAT HE IS CALLING IN REGARD TO A CHARGE TO MEDICARE, IMMEDIATELY ASK HIM IF HE HAS THE MSN OR ONLINE NOTICE FOR THAT CHARGE IN FRONT OF HIM.

IF THE CALLER INDICATES IMMEDIATELY THAT SHE IS SEEKING CLARIFICATION OF INFORMATION ON THE MSN, EXPLAIN TO THE CALLER THAT THIS IS A FRAUD LINE AND DIRECT HER TO 1-800-MEDICARE.

IF THE CALLER INDICATES THAT HE SUSPECTS MEDICARE FRAUD, GIVE THE CALLER A CHANCE TO EXPLAIN THE SITUATION IN HIS OWN WORDS, THOUGH YOU MAY HAVE TO PROMPT HIM WITH POINTED QUESTIONS.

YOUR DECISION ON WHETHER OR NOT TO RECORD A COMPLAINT WILL DEPEND ON THE ANSWERS TO THREE BASIC QUESTIONS:

(1) DID THE BENEFICIARY RECEIVE THE SERVICES IN QUESTION?

(2) DOES THE BENEFICIARY KNOW THE PROVIDER LISTED?

(3) DID MEDICARE APPROVE/COVER THE SERVICES IN QUESTION?

ALL THIS INFORMATION WILL BE LISTED ON THE MEDICARE NOTICE.

THE MOST COMMON SCENARIO IN WHICH YOU TAKE A COMPLAINT WILL BE WHERE THE BENEFICIARY —

(1) DID NOT RECEIVE THE SERVICE

(2) DOES NOT KNOW THE PROVIDER

(3) MEDICARE PAID FOR THE SERVICE.

LISTEN CAREFULLY TO THE CALLER'S OVERVIEW OF THE SITUATION TO SEE IF SHE PROVIDES UNAMBIGUOUS ANSWERS TO THESE QUESTIONS.

IF NOT, YOU WILL NEED TO POSE THE QUESTIONS DIRECTLY.

DID THE BENEFICIARY RECEIVE THE SERVICE?

PERHAPS THE MOST IMPORTANT QUESTION A REVIEWING AGENCY WILL CONSIDER WHEN DECIDING WHETHER TO PURSUE CORRECTIVE ACTION AGAINST A PROVIDER IS WHETHER OR NOT THE PROVIDER HAS BILLED MEDICARE FOR SERVICES THAT WERE NOT ACTUALLY PERFORMED.

AS STRANGE AS IT SOUNDS, SOME CALLERS MAY HAVE TROUBLE GIVING YOU A DIRECT ANSWER TO THIS QUESTION.

FOR THE PURPOSES OF THIS QUESTION, THE INFORMATION YOU ARE SEEKING WILL BE FOUND ON THE MSN UNDER THE HEADINGS "SERVICES PROVIDED" AND "SERVICE DATE(S)."

IN ORDER TO DO THIS, YOU NEED TO POSE CLOSED-ENDED QUESTIONS BASED ON INFORMATION FROM THE MSN PROVIDED BY THE CALLER.

FOR EXAMPLE, IF THE CALLER TELLS YOU THAT THE CHARGE IN QUESTION IS FOR AN OFFICE/OUTPATIENT VISIT ON 1/15/08, TO CLARIFY THE SITUATION YOU SHOULD ASK —

> "DID YOU MAKE AN OFFICE/OUTPATIENT VISIT ON 1/15/08?"
> NOT
> "DID YOU RECEIVE THE SERVICES?"

AN UNAMBIGUOUS ANSWER TO THIS QUESTION WOULD BE —

> "YES, I DID MAKE AN OFFICE/OUTPATIENT VISIT ON THAT DATE."
> OR
> "NO, I DID NOT MAKE AN OFFICE/OUTPATIENT VISIT ON THAT DATE."

HERE ARE SOME OTHER POSSIBLE ANSWERS THAT WILL REQUIRE SOME FURTHER PROBING ON YOUR PART.

> "WELL, I WENT TO THE OFFICE, BUT..."
>
> WORDS TO THIS EFFECT SUGGEST THAT THE BENEFICIARY DID RECEIVE SOME TYPE OF SERVICES FROM THE PROVIDER. EVEN THOUGH THE BENEFICIARY MAY HAVE A GRIEVANCE AGAINST THE PROVIDER, IT IS LIKELY THAT OUR OFFICE IS NOT THE

RIGHT PLACE TO PURSUE THE ISSUE. (SEE "QUALITY OF CARE COMPLAINTS")

"I CAN'T BELIEVE IT COST THIS MUCH."

DO NOT CONFUSE A CALLER'S "STICKER SHOCK" WITH THE ISSUE OF WHETHER OR NOT THE CALLER RECEIVED THE SERVICE.

"I'M NOT SURE WHAT THIS MEANS"

NOT ALL SERVICE DESCRIPTIONS WILL BE AS STRAIGHTFORWARD AS "OFFICE/OUTPATIENT VISIT." SOME WILL INCLUDE PROCEDURE NAMES OR ABBREVIATIONS THAT ARE DIFFICULT FOR A NON-SPECIALIST TO UNDERSTAND. HOWEVER, JUST BECAUSE A CALLER DOES NOT UNDERSTAND A SERVICE DESCRIPTION DOES NOT MEAN THAT HE DID NOT RECEIVE THE SERVICE. HE SHOULD PROBABLY CALL THE MEDICARE CONTRACTOR FOR AN EXPLANATION OF THE CODE.

"THAT WAS SO LONG AGO, I DON'T REMEMBER."

KEEP IN MIND THAT MANY OF OUR CALLERS MAY BE BEGINNING TO EXPERIENCE MEMORY PROBLEMS. DESPITE THE CALLER'S GOOD INTENTIONS, WE TAKE OUR COMPLAINTS VERY SERIOUSLY, THUS WE MUST INSIST ON A STRONG DEGREE OF CERTAINTY. IF A CALLER TELLS YOU THIS, YOU MIGHT ASK IF HE HAS A FAMILY MEMBER OR FRIEND WHO COULD HELP HIM.

"I DON'T KNOW THIS DOCTOR."

THIS DOES NOT ANSWER THE QUESTION OF WHETHER OR NOT THE BENEFICIARY RECEIVED THE SERVICE. A CALLER MIGHT ASSUME THAT IF SHE DOES NOT KNOW THE PROVIDER LISTED, THEN SHE MUST NOT HAVE RECEIVED THE SERVICE. HOWEVER, THERE ARE A VARIETY OF SERVICES — SUCH AS LAB WORK — THAT CAN BE PERFORMED WITHOUT THE

BENEFICIARY SEEING, OR EVEN KNOWING, THE PROVIDER.

"I WAS NEVER IN (NAME OF TOWN)."

SIMILAR TO THE ABOVE, THIS DOES NOT ANSWER THE QUESTION OF WHETHER THE BENEFICIARY RECEIVED THE SERVICE. THE MSN WILL LIST A BUSINESS ADDRESS FOR THE PROVIDER THAT MIGHT BE DIFFERENT FROM THE LOCATION WHERE THE SERVICES WERE ACTUALLY RENDERED. ALSO, IT MAY THE SAME SITUATION DESCRIBED ABOVE WHERE A SERVICE WAS RENDERED IN THE ABSENCE OF THE BENEFICIARY.

DOES THE BENEFICIARY KNOW THE PROVIDER?

IF A BENEFICIARY HAS SOME KIND OF HISTORY WITH A DOCTOR OR HOSPITAL, IT GREATLY RAISES THE PROBABILITY THAT A DISPUTED CHARGE IS THE RESULT OF SOME KIND OF CLERICAL ERROR RATHER THAN AN ATTEMPT TO DEFRAUD MEDICARE.

SO IF A CALLER INDICATES THAT HE KNOWS THE PHYSICIAN BUT DID NOT RECEIVE A PARTICULAR SERVICE, YOU SHOULD SUGGEST THAT HE CALL THE DOCTOR TO QUESTION THE CHARGE TO MEDICARE BEFORE REPORTING IT TO US.

UNFORTUNATELY, THE WAY THAT PROVIDER INFORMATION IS PRESENTED ON THE MSN SOMETIMES CONFUSES THE BENEFICIARIES.

THE NAME AND ADDRESS OF THE PROVIDER APPEARS IN BOLD PRINT.

IF A CALLER SAYS THAT HE HAS NEVER BEEN TO THE ADDRESS OR TOWN LISTED ON THE NOTICE, YOU MAY NEED TO POINT OUT THAT THE ADDRESS LISTED IS A BILLING ADDRESS WHICH MAY BE DIFFERENT THAN THE PLACE WHERE THE SERVICES WHERE

RENDERED.

IF A CALLER TELLS YOU THAT THERE IS NO ADDRESS LISTED FOR THE PROVIDER ON THE NOTICE HE IS LOOKING AT, THEN HE IS NOT LOOKING AT AN MSN.

IF THIS SERVICE WAS PERFORMED BY A PHYSICIAN WHO BELONGS TO A GROUP PRACTICE, THEN THE GROUP PRACTICE NAME WILL APPEAR ABOVE THE ADDRESS, BUT THE INDIVIDUAL PHYSICIAN'S NAME WILL ALSO APPEAR.

IF A CALLER SAYS THAT SHE RECOGNIZES HER PHYSICIAN'S NAME BUT NOT "CITYWIDE FAMILY PHYSICIANS," YOU SHOULD SUGGEST THAT SHE CALL HER PHYSICIAN FOR CONFIRMATION THAT THE PHYSICIAN BELONGS TO THIS GROUP.

FOR SOME SERVICES, THE MSN WILL ALSO LIST THE NAME OF THE PHYSICIAN WHO REFERRED THE BENEFICIARY FOR SERVICES (USING THE NOTATION "REFERRED BY").

THE CALLER MAY NOT RECOGNIZE THE NAME OF THE REFERRING PHYSICIAN. FOR EXAMPLE, THE HEAD OF HOSPITAL'S RADIOLOGY DEPARTMENT MIGHT SIGN OFF AS THE REFERRING PHYSICIAN FOR ALL X-RAYS PERFORMED IN THE HOSPITAL.

IF THE CALLER'S COMPLAINT CENTERS ON THE FACT THAT HE DOES NOT RECOGNIZE A PHYSICIAN'S NAME, ASK HIM SPECIFICALLY IF IT SAYS "REFERRED BY" NEXT TO THE PHYSICIANS NAME.

THE REFERRING PHYSICIAN DOES NOT RECEIVE ANY PAYMENT FROM MEDICARE, SO YOU WOULD NOT WANT TO TAKE A COMPLAINT JUST BECAUSE THE CALLER DOES NOT KNOW THAT NAME.

DID MEDICARE PAY FOR THE SERVICE?

MEDICARE DOES NOT AUTOMATICALLY PAY PROVIDERS FOR EVERY CLAIM SUBMITTED.

THE MEDICARE CONTRACTOR ONLY PAYS ON THOSE CLAIMS WHICH IT CONSIDERS TO HAVE BEEN DELIVERED AND TO HAVE BEEN MEDICALLY APPROPRIATE.

IF THE MEDICARE CONTRACTOR DENIES PAYMENT ON A CLAIM, THERE IS NO NEED FOR US TO TAKE A COMPLAINT ON THE MATTER SINCE NO MEDICARE FUNDS WERE PAID OUT.

THE MSN INDICATES WHETHER OR NOT MEDICARE PAID FOR A PARTICULAR CLAIM.

IF THE CLAIM IS FOR A SERVICE RENDERED BY AN INDIVIDUAL PROVIDER, FOR TESTS PERFORMED BY A CLINICAL LABORATORY, OR FOR MEDICAL EQUIPMENT/SUPPLIES, THE MSN WILL INDICATE THE AMOUNT THAT THE PROVIDER CHARGED FOR THE SERVICE, AND THE AMOUNT THAT THE MEDICARE CONTRACTOR APPROVED.

> IF THE AMOUNT APPROVED IS ANYTHING OTHER THAN $0.00, THEN MEDICARE PAID SOMETHING FOR THE SERVICE.
>
> IF THE AMOUNT APPROVED IS $0.00, THEN MEDICARE DENIED THE CLAIM AND PAID NOTHING.

IF THE CLAIM IS SUBMITTED BY A FACILITY (HOSPITAL, PHYSICAL THERAPY CLINIC, HOME HEALTH AGENCY) THE MSN WILL INDICATE THE AMOUNT THAT THE PROVIDER CHARGED FOR THE SERVICE AND THE “NON-COVERED CHARGES” FOR THE CLAIM.

> IF THE NON-COVERED CHARGES ARE $0.00, THEN MEDICARE PAID SOMETHING FOR THE SERVICE (THE ACTUAL AMOUNT PAID IS USUALLY INDICATED IN THE “NOTES” SECTION).

IF THE NON-COVERED CHARGES ARE EQUAL TO THE AMOUNT CHARGED, THEN MEDICARE DENIED THE CLAIM AND PAID NOTHING.

NEEDLESS TO SAY, THIS DISTINCTION MAY CONFUSE SOME OF OUR CALLERS.

SO, IN ORDER TO MAKE SURE THAT MEDICARE PAID FOR A PARTICULAR CLAIM, YOU MIGHT HAVE TO GUIDE THE CALLER THROUGH HER MSN TO LEARN THE MEDICARE CONTRACTOR'S DETERMINATION FOR THAT SERVICE.

MORE ON THE MEDICARE SUMMARY NOTICE

THE MSN WILL ALWAYS LIST THE BENEFICIARY'S NAME AND ADDRESS.

THERE WILL BE A BOX MARKED "CUSTOMER SERVICE INFORMATION" THAT WILL LIST THE LAST FIVE DIGITS OF THE BENEFICIARY'S MEDICARE NUMBER, THE PHONE NUMBER FOR MEDICARE (1-800-633-4227), AND INSTRUCTIONS ON WHERE TO DIRECT INQUIRIES ON THAT PARTICULAR CLAIM (E.G., "ASK FOR MEDICAL SUPPLIES).

SOME BENEFICIARIES MAY BE CONFUSED BECAUSE THE MSN LISTS DATES IN THREE DIFFERENT PLACES:

- AT THE VERY TOP OF THE FORM, YOU WILL SEE THE DATE THAT THE MSN WAS PRINTED.

- THE MSN WILL LIST A RANGE OF DATES FOLLOWING THE NOTATION "SUMMARY OF CLAIMS PROCESSED" — THIS TIME PERIOD REFERS TO WHEN THE CLAIMS WERE RECEIVED BY THE CONTRACTOR, NOT WHEN THE SERVICES WERE RENDERED.

- IN THE BOX PRESENTING THE SERVICE INFORMATION, ONE OF

THE COLUMNS WILL BE LABELED "SERVICE DATE(S)" — THESE DATES REFER TO WHEN THE SERVICES WERE RENDERED.

- IF THE "SERVICE DATE(S)" FIELD LISTS A RANGE OF DATES, THIS MEANS THAT THE SERVICE WAS RENDERED AT SOME POINT IN THAT TIME FRAME; IT DOES NOT MEAN THAT THE SERVICE WAS RENDERED ON EVERY ONE OF THE DATES.

FOR EACH CHARGE PROCESSED, THE MSN WILL LIST THE BENEFICIARY'S CO-INSURANCE RESPONSIBILITY UNDER THE HEADING "YOU MAY BE BILLED."

- THE MSN IS NOT A BILL, SO THE BENEFICIARY SHOULD NOT SEND ANY PAYMENT AS A RESULT OF RECEIVING THIS FORM.

- IF THE CALLER COMPLAINS THAT SHE HAS ALREADY PAID THIS AMOUNT TO THE PROVIDER, OR THAT SHE HAS A SUPPLEMENTAL INSURANCE POLICY THAT WILL PAY THE AMOUNT, YOU MAY NEED TO REASSURE HER THAT THE MSN IS NOT A BILL — IT SIMPLY INDICATES THE CONTRACTOR'S CALCULATION OF THE BENEFICIARY'S COST-SHARING.

IF A PARTICULAR CHARGE INVOLVES SOME UNUSUAL ACTION OR CALCULATION THE MSN WILL SUPPLEMENT THE INFORMATION.

- THE MSN WILL PROMPT THE BENEFICIARY TO THIS INFORMATION WITH AN ENTRY IN THE "NOTES" COLUMN, GUIDING THE BENEFICIARY TO THE NOTES SECTION (FOUND UNDER THE CHARGE INFORMATION).

- FOR EXAMPLE, IF THE MEDICARE CONTRACTOR DENIES PAYMENT ON A PARTICULAR CHARGE THE MSN WILL EXPLAIN THE REASON FOR THIS DECISION IN A NOTE.

TYPES OF COMPLAINTS

BY NOW YOU SHOULD UNDERSTAND THE INS AND OUTS OF YOUR

THREE BASIC SCREENING QUESTIONS:

1) DID THE BENEFICIARY RECEIVE THE SERVICES?

2) DOES THE BENEFICIARY KNOW THE PROVIDER?

3) DID MEDICARE PAY FOR THE SERVICES?

THE COMBINATION OF ANSWERS THAT WOULD PROMPT YOU TO TAKE A COMPLAINT WOULD BE IF —

1) THE BENEFICIARY DID NOT RECEIVE THE SERVICE

2) THE BENEFICIARY DOES NOT KNOW THE PROVIDER

3) MEDICARE PAID FOR THE SERVICE.

THERE ARE SEVERAL OTHER SPECIAL SITUATIONS THAT WILL SIGNAL THAT YOU SHOULD TAKE A COMPLAINT.

- YOU WOULD TAKE A COMPLAINT IF THE BENEFICIARY ALLEGES THAT A PROVIDER HAS BILLED THE BENEFICIARY FOR AN AMOUNT GREATER THAN THE AMOUNT THE MSN INDICATES THE BENEFICIARY MAY BE BILLED. BUT BEFORE YOU TAKE A COMPLAINT UNDER THIS CIRCUMSTANCE, YOU SHOULD THAT THE BENEFICIARY TRY TO CONTACT THE PROVIDER FIRST.

- IF THE CALLER ALLEGES THAT THE SERVICES RENDERED WERE *UNNECESSARY*, ASK WHY THE CALLER CONSIDERS THIS TO BE THE CASE. IF THE CALLER PRESENTS TRULY SUSPICIOUS SITUATION (NOT JUST THAT OF A LAYMAN QUESTIONING A PHYSICIAN'S JUDGEMENT), OFFER TO TAKE A COMPLAINT.

COMPLAINT INFORMATION

FOR EVERY COMPLAINT THAT YOU TAKE FROM A MEDICARE BENEFICIARY (OR FAMILY MEMBER), IN ADDITION TO THE NAMES,

ADDRESSES AND PHONE NUMBERS OF THE CALLER AND PROVIDER, YOU SHOULD ASK FOR —

- IF THE CALLER IS NOT THE BENEFICIARY, THE BENEFICIARY'S NAME AND THE CALLER'S RELATIONSHIP TO THE BENEFICIARY
- THE BENEFICIARY'S MEDICARE NUMBER
- THE SERVICE DATE(S)
- THE SERVICE DESCRIPTION(S)
- THE AMOUNT(S) CHARGED
- THE AMOUNT(S) APPROVED, OR THE NON-COVERED CHARGES.

LOOK AT THE "SAMPLE COMMENTS" FOR HOW THIS INFORMATION SHOULD BE PRESENTED.

YOU MAY NEED TO SUMMARIZE INFORMATION IN YOUR COMMENTS IF THERE ARE NUMEROUS CHARGES.

DOOR-TO-DOOR SOLICITATIONS

MAJORITY OF OUR CALLS FROM BENEFICIARIES WILL RELATE TO CHARGES THAT APPEAR ON MEDICARE SUMMARY NOTICES, BUT THE PHONE MENU ALSO INVITES CALLERS TO THE REPORT "PHONY SERVICE PROVIDERS" AND "DOOR-TO-DOOR SOLICITATION."

ALTHOUGH PROVIDERS ARE ALLOWED TO MARKET THEIR SERVICES THROUGH GENERAL MEDIA, THEY ARE PROSCRIBED FROM MAKING UNSOLICITED CONTACTS WITH BENEFICIARIES. KEEPING IN MIND THAT ANY UNSOLICITED CONTACT IS SUSPECT, SOME OF THE FACTORS THAT SUGGEST FRAUDULENT ACTIVITY WOULD BE –

- SUGGESTING THE NEED FOR A NEW SERVICE, EQUIPMENT OR

SUPPLY

- SUGGESTING THE NEED FOR AN ENHANCEMENT (E.G., MORE FREQUENT VISITS) FOR A SERVICE, EQUIPMENT, OR SUPPLY THAT THE BENEFICIARY IS ALREADY RECEIVING

- GUARANTEEING THAT MEDICARE WILL COVER THE SERVICE, EQUIPMENT OR SUPPLY

- USING MEDICARE COVERAGE AS INCENTIVE FOR REQUESTING NEW SERVICE, EQUIPMENT OR SUPPLY

- OFFERING ANYTHING OF VALUE – CASH, WAIVER OF MEDICARE CO-INSURANCE, "DOOR PRIZES" – TO INDUCE A REQUEST FOR SERVICES, EQUIPMENT OR SUPPLY.

YOU SHOULD OFFER TO TAKE A COMPLAINT IF A CALLER PRESENTS SUCH A SCENARIO. IT IS DOUBTFUL THAT THE CALLER WILL HAVE AN MSN WITH PRECISE CHARGE INFORMATION, BUT YOU SHOULD TRY TO SOLICIT AS MUCH INFORMATION YOU CAN THAT CAN IDENTIFY THE INDIVIDUALS AND/OR COMPANIES INVOLVED.

YOU SHOULD ALSO TRY TO PROVIDE DETAILS ON THE SOLICITATION ITSELF; IN PARTICULAR, DO NOT SETTLE FOR "I WAS CONTACTED BY…" AS AN EXPLANATION: TRY TO FIND OUT IF THIS WAS A "COLD CALL" OR DID THE BENEFICIARY RESPOND TO AN ADVERTISEMENT OF SOME KIND.

ADMINISTRATIVE PROBLEMS

BECAUSE OF THE OIG'S BROAD ENFORCEMENT POWERS, SOME CALLERS HAVE A MISTAKEN VIEW OF OUR FUNCTION AS SOME TYPE OF CONSUMER OMBUDSMAN FOR ALL MEDICARE TRANSACTIONS. THUS, THEY WILL CALL US IF THEY FEEL THAT MEDICARE HAS TAKEN TOO LONG TO PROCESS A CLAIM, THAT MEDICARE DENIED A CLAIM IMPROPERLY, OR THAT A DOCTOR HAS NOT REFUNDED AN OVERPAYMENT. THEY EXPECT THAT SOMEONE FROM THE OIG WILL

INTERVENE BY PHONING THE MEDICARE OFFICE OR PROVIDER TO SORT OUT THE MATTER.

YOU NEED TO TRY TO EXPLAIN TO THE CALLER THAT THE OIG CONDUCTS INVESTIGATIONS, AUDITS AND INSPECTIONS. THE OIG ALMOST NEVER INTERVENES IN INDIVIDUAL CASES.

CALLS INVOLVING A MEDICARE DECISION SHOULD BE HANDLED BY THE CONTRACTOR. IF A CALLER BELIEVES THAT A MEDICARE CONTRACTOR'S PERFORMANCE HAS BEEN UNRESPONSIVE OR INEFFICIENT, AND REFUSES TO SPEAK WITH THE CONTRACTOR ANY FURTHER, HE CAN BE REFERRED TO THE CMS REGIONAL OFFICE AS A BACK UP.

IF THE CALLER SIMPLY INSISTS ON MAKING A COMPLAINT, AND YOUR JUDGEMENT TELLS YOU THAT SOME VIOLATION OF REGULATIONS OR PROCEDURES HAS OCCURRED, YOU CAN OFFER TO MAKE A COMPLAINT, BUT BE SURE THAT THE CALLER IS AWARE THAT HIS COMPLAINT WILL BE PROCESSED LIKE ANY OTHER TIP WE RECEIVE; IT WILL NOT BE EXPEDITED BECAUSE THE CALLER HAS A VESTED PERSONAL INTEREST IN THE OUTCOME. THIS MAY DISSUADE A CALLER WHO CALCULATES THAT OUR OFFICE WILL HELP WITH A REFUND OR OTHER TRANSACTION.

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SAMPLE COMMENTS

MEDICARE BENEFICIARY COMPLAINTS

1. MR. SMITH RECEIVED A MEDICARE SUMMARY NOTICE SHOWING THAT DR. JONES BILLED MEDICARE $75.00 ($52.33 APPROVED) FOR AN OFFICE/OUTPATIENT VISIT, NEW, ON 2/1/08. MR. SMITH STATES THAT HE HAS NEVER HEARD OF DR. JONES AND RECEIVED NO MEDICAL SERVICE ON THAT DATE.

2. MR. SMITH RECEIVED A MEDICARE SUMMARY NOTICE SHOWING

THAT CITY HOSPITAL BILLED MEDICARE $250.00 ($0.00 NON-COVERED CHARGES) FOR AN EMERGENCY ROOM VISIT ON 1/1/08. MR. SMITH STATES HE VISITED NO EMERGENCY ROOM ON THIS DATE.

3. MRS. SMITH RECEIVED A MEDICARE SUMMARY NOTICE SHOWING THAT ACME HOME CARE BILLED MEDICARE $500.00 FOR 5 SKILLED NURSE VISITS AND $750.00 FOR 10 AIDE VISITS (MEDICARE COVERED ALL CHARGES) FOR THE PERIOD 2/1/07-2/15/07. MRS. SMITH STATES THAT SHE RECEIVED CARE FROM THIS AGENCY, BUT ACCORDING TO HER RECORDS THERE WERE ONLY 2 SKILLED NURSE VISITS AND 5 AIDE VISITS.

4. MR. SMITH RECEIVED A MEDICARE SUMMARY NOTICE FOR CHARGES SUBMITTED BY CITY HOSPITAL FOR A VISIT HE MADE ON 2/1/08. AMONG THE CHARGES WAS $500.00 FOR 3 X-RAYS. ALTHOUGH HE WAS AT CITY HOSPITAL ON THAT DATE, HE STATES THAT THERE WERE NO X-RAYS PERFORMED.

MEDICARE BENEFICIARY COMPLAINTS (3RD PARTY)

1. MR. SMITH CALLED ON BEHALF OF HIS WIFE, MARY SMITH (123-45-6789B). SHE RECEIVED A MEDICARE SUMMARY NOTICE SHOWING THAT ACME MEDICAL LABORATORIES BILLED MEDICARE $150.00 ($86.15 APPROVED) FOR 4 BLOOD TESTS ON 12/1/07. MR. SMITH STATES THAT HIS WIFE DID NOT PROVIDE ANY BLOOD SAMPLES FOR TESTING AROUND THIS TIME. HE CALLED MRS. SMITH'S PHYSICIAN TO CONFIRM THAT HE HAD NOT ORDERED ANY TESTING.

2. MRS. SMITH CALLED ON BEHALF OF HER HUSBAND, JOSEPH SMITH (123-45-6789A). MR. SMITH RECEIVED AN MEDICARE SUMMARY NOTICE SHOWING THAT DR. JONES BILLED MEDICARE $100.00 ($76.52 APPROVED) FOR HOSPITAL CARE, INITIAL ON 2/1/08 AND $75.00 ($49.77 APPROVED) FOR SUBSEQUENT HOSPITAL CARE ON 2/2/08. MRS. SMITH STATED THAT HER HUSBAND HAS NEVER HEARD OF DR. JONES AND HE WAS NOT IN ANY HOSPITAL ON THESE

DATES.

3. MR. SMITH CALLED ON BEHALF OF HIS WIFE, MARY SMITH (123-45-6789B). MRS. SMITH RECEIVED A MEDICARE SUMMARY NOTICE SHOWING THAT CITY HOSPITAL BILLED MEDICARE $85.00 ($0.00 NON-COVERED CHARGES) FOR A CHEST X-RAY ON 2/1/08. MR. SMITH STATED THAT HIS WIFE WENT IN FOR AN X-RAYS OF HER ANKLE. MR. SMITH CONTACTED HIS WIFE'S PHYSICIAN, WHO STATED THAT HE HAD RECEIVED A COPY OF THIS X-RAY, BUT THAT HE HAD NOT ORDERED IT AND THAT IT WAS NOT NECESSARY.

DOOR-TO-DOOR SOLICITATIONS

1. MS. HART RESIDES AT RESTFUL ACRES, A SENIOR APARTMENT COMPLEX. SHE HEARD FROM SEVERAL RESIDENTS THAT A WOMAN NAMED SHIRLEY HAS BEEN GOING DOOR-TO-DOOR TRYING TO CONVINCE RESIDENTS TO ORDER SCOOTERS. SHIRLEY ASSURES THEM THAT MEDICARE WILL PAY FOR THESE ITEMS. FOR THOSE WHO ARE RELUCTANT SHE ARGUES THAT MEDICARE BENEFITS ARE GOING TO BE CUT SOON SO THEY SHOULD ORDER SCOOTERS BEFORE IT IS TOO LATE. ACCORDING TO HER CARD SHIRLEY WORKS FOR MOBILE WORLD. MS. HART STATED THAT MOBILE WORLD DELIVERED A SCOOTER LAST WEEK TO ESSIE RIDER. MS. HART DOES NOT FEEL MS. RIDER NEEDS A SCOOTER.

2. THE ANONYMOUS CALLER ALLEGED THAT HE WAS APPROACHED IN FRONT OF ROGERS PHARMACY IN EAST LOS ANGELES BY A MAN NAMED CARLOS. CARLOS ASKED THE CALLER IF HE WAS ON MEDICARE. CARLOS THEN OFFERED THE CALLER $50 IF HE WOULD GO WITH HIM TO A CLINIC. CARLOS DROVE THE CALLER TO STAT URGENT CARE CLINIC. SOMEONE AT THE FRONT DESK COPIED THE CALLER'S MEDICARE CARD AND GAVE HIM $50 IN CASH. THE CALLER DID NOT RECEIVE ANY MEDICAL CARE. CARLOS GAVE THE CALLER HIS CARD AND SAID TO CALL WHENEVER HE OR ANY OF HIS FRIENDS WANTED TO MAKE $50.

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QUALITY OF CARE

SOME CALLERS WILL ACKNOWLEDGE THAT THEY VISITED A PARTICULAR PHYSICIAN OR RECEIVED SERVICES FROM A HOSPITAL, BUT WILL ARGUE THAT THE QUALITY OF THE CARE WAS SO POOR THAT MEDICARE SHOULD NOT PAY FOR IT.

IN GENERAL THE OIG DOES NOT TAKE THE LEAD IN INVESTIGATING QUALITY OF CARE ISSUES.

WHEN YOU RECEIVE A QUALITY OF CARE COMPLAINT, YOU NEED TO EXPLAIN TO THE CALLER THAT THE HOTLINE'S MAIN FOCUS IS TO IDENTIFY FRAUDULENT PROVIDERS, I.E., ENTITIES THAT ARE SYSTEMATICALLY BILLING FOR SERVICES THAT ARE NOT BEING PROVIDED.

FURTHER EXPLAIN THAT ALTHOUGH THE CALLER MIGHT HAVE A LEGITIMATE GRIEVANCE, OUR OFFICE IS NOT THE RIGHT VENUE TO REGISTER A COMPLAINT, BECAUSE THE FEDERAL GOVERNMENT DOES NOT LICENSE HEALTH CARE PROVIDERS OR INVESTIGATE PROVIDER CARE.

YOU CAN, HOWEVER, REFER THE CALLER TO THE STATE AGENCY THAT CAN REVIEW THE QUALITY OF CARE ISSUE —

- IF THE PROVIDER IN QUESTION IS A HOSPITAL, OR ANOTHER FACILITY, REFER THE CALLER TO HER STATE **QUALITY IMPROVEMENT ORGANIZATION** (QIO) — QIOS ARE CONTRACTED BY CMS TO REVIEW QUALITY OF CARE ISSUES INVOLVING MEDICARE BENEFICIARIES

- IF THE PROVIDER IN QUESTION IS A PHYSICIAN OR ANOTHER INDIVIDUAL PRACTITIONER, REFER THE CALLER TO HIS STATE

MEDICAL REVIEW BOARD

- IF THE PROVIDER IN QUESTION IS A LONG TERM CARE FACILITY — NURSING HOME, SKILLED NURSING FACILITY, REHABILITATION CENTER, ADULT HOME — REFER THE CALLER TO HER STATE **LONG TERM CARE OMBUDSMAN.**

THESE AGENCIES ARE SPECIFICALLY TASKED WITH REVIEWING CONCERNS ABOUT QUALITY OF CARE — IF ONE OF THESE AGENCIES CONFIRMS A COMPLAINT, IT WILL CONVEY THIS FINDING TO THE APPROPRIATE MEDICARE OFFICE, WHICH COULD RESULT IN THE RECOVERY OF ANY PAYMENT.

ABUSE/NEGLECT IN LONG TERM CARE FACILITIES

THE ONE EXCEPTION TO THE ABOVE GUIDANCE WOULD BE IF THE CALL INVOLVES NEGLECT OR ABUSE IN A LONG TERM CARE FACILITY — EVEN IF THE RESIDENT IS NOT A MEDICARE BENEFICIARY.

NATURALLY THERE IS A FINE LINE BETWEEN “QUALITY OF CARE” AND “NEGLECT AND ABUSE,” BUT AS A RULE OF THUMB YOU SHOULD LOOK AT THE LATTER IN TERMS OF SITUATIONS THAT IMPERIL THE HEALTH, OR EVEN THE LIVES, OF RESIDENTS, NOT THAT SIMPLY CAUSE MINOR INCONVENIENCES.

WHEN IN DOUBT, ERR ON THE SIDE OF CAUTION AND TAKE A COMPLAINT.

HOSPITAL ERRORS

IN RECENT YEARS CMS HAS INTRODUCED NEW REGULATIONS STATING THAT MEDICARE/MEDICAID WILL NOT PAY FOR TREATMENT RESULTING FROM “REASONABLY PREVENTABLE” ERRORS, SUCH AS TRANSFUSIONS WITH INCOMPATIBLE BLOOD OR FAILING TO

RETRIEVE A SPONGE DURING SURGERY. NOTE THAT PROVISION ONLY REFERS TO ADDITIONAL SERVICES CAUSED BY THE ERROR.

THIS COULD CALL FOR OIG ACTION SHOULD A HOSPITAL VIOLATE THESE REGULATIONS BUT THE HOTLINE IS STILL NOT THE PROPER VENUE TO REPORT THE ERROR ITSELF. THE ONLY INSTANCE WHERE WE SHOULD TAKE A COMPLAINT IS IN AN INSTANCE WHERE THE ERROR HAS BEEN ESTABLISHED, EITHER BY ADMISSION OF THE HOSPITAL OR THROUGH REVIEW BY AN INVESTIGATIVE AGENCY, YET THE HOSPITAL STILL BILLED MEDICARE/MEDICAID FOR RESULTING SERVICE.

CALLS FROM PSYCHIATRIC FACILITIES

AT SOME POINT YOU WILL PROBABLY RECEIVE CALLS FROM PATIENTS WHO HAVE BEEN COMMITTED AGAINST THEIR WILL TO A PSYCHIATRIC INSTITUTION FOR TREATMENT OR EVALUATION. SUCH COMMITTALS ARE OFTEN INITIATED BY LOCAL POLICE. STANDARDS VARY FROM STATE TO STATE AS TO THE LEGAL STANDARDS FOR COMMITTAL.

FEW OF THESE CALLS RAISE ISSUES THAT IMPLICATE THE JURISDICTION OF OIG. FOR MANY, THE PRIMARY TARGET OF THEIR COMPLAINT WILL BE THE LOCAL POLICE FORCE AND JUDICIARY. BUT SOME CALLERS WILL ARGUE THAT THE FACILITY, EITHER BY ADMITTING THEM OR BY REFUSING TO DISCHARGE THEM, HAS DONE SO ON THE BASIS OF A FALSE DIAGNOSIS AND THAT THEIR TREATMENT CONSTITUTES UNNECESSARY SERVICE. (AND MANY OF THE CALLERS WILL BE MEDICARE BENEFICIARIES.)

YOU NEED TO TRY TO EXPLAIN TO SUCH CALLERS THAT OIG WILL NOT INTERVENE ON THEIR BEHALF. THEIR BEST HOPE IS TO PURSUE A LEGAL APPEAL OF THEIR COMMITTAL.

COMPLAINT INFORMATION

YOU WILL NEED TO HAVE THE CALLER DESCRIBE IN SOME DETAIL

WHAT NEGLECT OR ABUSE IS TAKING PLACE — IT IS NOT SUFFICIENT TO SAY SIMPLY THAT RESIDENTS ARE BEING MISTREATED.

THE INFORMATION YOU WILL GATHER WILL NOTE THE DAMAGE SUFFERED BY THE RESIDENT, SUCH AS BRUISES, SORES, RAPID WEIGHT LOSS, OR EMOTIONAL DISTRESS.

YOU SHOULD NOTE IF THE SITUATION HAS CAUSED THE RESIDENT TO BE HOSPITALIZED.

ASK IF THE RESIDENT'S PERSONAL PHYSICIAN HAS WITNESSED EVIDENCE OF THE ABUSE.

ASK IF THE CALLER HAS RAISED THE SITUATION WITH THE FACILITY ADMINISTRATION, AND IF SO, WHAT WAS THE RESPONSE.

NOTE ANY FACILITY STAFF WHO THE CALLER FEELS MAY BE DIRECTLY RESPONSIBLE FOR THE ABUSE OR NEGLECT — ESPECIALLY IMPORTANT FOR ALLEGATIONS OF PHYSICAL ABUSE.

NOTE ANY FACILITY STAFF, OR ANYONE ELSE, WHO CAN CONFIRM THE ALLEGATION. IN ADDITION TO TAKING A COMPLAINT, YOU SHOULD REFER THE CALLER TO HER STATE LONG-TERM CARE OMBUDSMAN.

ALTHOUGH WE EXPEDITE THE REFERRAL OF SUCH COMPLAINTS, IF ANY RESIDENTS OF THE FACILITY IN QESTION ARE IN IMMINENT DANGER TO THEIR HEALTH THE CALLER SHOULD NOT HESITATE TO SUMMON EMERGENCY HELP.

SOURCES

BE PREPARED FOR THE FACT THAT CALLERS REPORTING ABUSE/NEGLECT, WHO WILL OFTEN BE CALLING ON BEHALF OF THEIR PARENTS OR OTHER ELDERLY RELATIVES, WILL BE HIGHLY EMOTIONAL.

THEREFORE, YOU WILL NEED TO MAINTAIN YOUR COMPOSURE AND CONVEY A SENSE OF SYMPATHY AS YOU EXPLAIN, IF NECESSARY, THAT OUR OFFICE CANNOT HANDLE THEIR COMPLAINT.

EXPERIENCE HAS SHOWN ALSO THAT SOME PEOPLE WILL TRY TO DRAW OUR OFFICE INTO A FAMILY DISPUTE OVER THE PROPER CARE OF A RELATIVE — SO BE ON GUARD FOR A CALLER WHO CAN NOT ARTICULATE ANY SPECIFIC DETAILS OF NEGLECT OR ABUSE, BUT WHO MAKES BITTER ALLUSIONS TO ANOTHER RELATIVE WHO CHOSE TO PLACE THE RESIDENT IN THE PARTICULAR FACILITY.

REFUSAL OF CARE/PATIENT DUMPING

SOME MEDICARE BENEFICIARIES WILL CALL TO COMPLAIN THAT A PROVIDER HAS DENIED THEM SERVICE ON THE GROUNDS THAT PROVIDERS WHO TAKE MEDICARE PAYMENTS ARE OBLIGATED TO TREAT ALL MEDICARE PATIENTS.

THE EMERGENCY TREATMENT AND LABOR ACT (EMTALA) ONLY REQUIRES MEDICARE-APPROVED HOSPITALS AND AMBULANCE COMPANIES TO EVALUATE AND STABILIZE **ANY PATIENT** REQUIRING EMERGENCY CARE, REGARDLESS OF THE PATIENT'S ABILITY TO PAY, NOT JUST MEDICARE PATIENTS.

HHS HAS RESPONSIBILITY FOR ENFORCING EMTALA, SO YOU SHOULD TAKE A COMPLAINT WHEN A CALLER RAISES THIS SITUATION. REMEMBER: EMTALA IS ONLY IMPLICATED IN CASES INVOLVING THE DENIAL OF EMERGENCY CARE **BY A HOSPITAL OR AMBULANCE SERVICE**. THIS IS SOMETIMES REFERRED TO AS "PATIENT DUMPING."

IF A CALLER FEELS THAT SHE (OR A FAMILY MEMBER) IS BEING DISCHARGED FROM AN INPATIENT FACILITY PREMATURELY, SHE SHOULD BE REFERRED TO THE QIO TO APPEAL THE DECISION.

IF A CALLER, REGARDLESS OF INSURANCE STATUS, COMPLAINS OF

BEING DENIED MEDICAL CARE ON THE BASIS OF RACE, GENDER, OR RELIGION, HE SHOULD BE REFERRED TO THE HHS OFFICE OF CIVIL RIGHTS.

IN JUST ABOUT ANY OTHER SITUATION, PROVIDERS HAVE A CHOICE OF WHETHER OR NOT TO TREAT A MEDICARE PATIENT, SO YOU WOULD NOT TAKE A COMPLAINT.

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SAMPLE COMMENTS

PATIENT NEGLECT/QUALITY OF CARE

1. MS. HATHAWAY CALLED ON BEHALF OF HER AUNT, BEULAH HOLMES (987654321D). MS. HOLMES IS A RESIDENT OF SHADY ELMS MANOR. MS. HATHAWAY STATES THAT WHEN SHE WENT TO VISIT HER AUNT ON 9/1/07 SHE OBSERVED HEAVY BRUISING ALONG HER ARMS. MS. HATHAWAY MADE THE STAFF CALL AN AMBULANCE. X-RAYS TAKEN AT THE HOSPITAL REVEALED THAT MS. HOLMES HAD A FRACTURE IN HER RIGHT WRIST. WHEN MS. HATHAWAY ASKED HARLAN JONES, THE ADMINISTRATOR AT SHADY ELMS, WHAT HAD HAPPENED, HE TOLD HER THAT HE HAD NO KNOWLEDGE OF THE INCIDENT. HE SUGGESTED THAT MS. HOLMES MIGHT HAVE TRIED TO GET UP DURING THE NIGHT AND FALLEN. LATER, MS. HATHAWAY WAS TOLD BY CAROL SMITH, A NURSE AT SHADY ELMS, THAT MS. HOLMES RECEIVED THE INJURY WHEN SHE WAS ROUGHLY TREATED BY KEVIN ANDERSON, AN AIDE AT THE FACILITY. MS. SMITH SAID THAT SHE HAD HEARD OF SIMILAR INCIDENTS INVOLVING OTHER RESIDENTS AND MR. ANDERSON.

2. MR. DAVIS CALLED ON BEHALF OF HIS MOTHER, ROSE DAVIS (876543219B). MRS. DAVIS RESIDES AT QUIET ACRES NURSING CENTER. MR. DAVIS STATES THAT WHEN HE VISITED HIS MOTHER ON 8/15/07 SHE APPEARED TO BE PALE AND IN GREAT DISCOMFORT. MR. DAVIS ASKED THE NURSE ON HIS MOTHER'S FLOOR IF SHE

KNEW WHAT WAS WRONG, AND SHE TOLD HIM THAT SHE HAD BEEN BUSY WITH ANOTHER PATIENT. MR. DAVIS IMMEDIATELY SUMMONED DR. GARY THOMAS, HIS MOTHER'S PHYSICIAN. DR. THOMAS DETERMINED THAT MRS. DAVIS WAS SUFFERING FROM SEVERE DEHYDRATION AND ORDERED THAT SHE BE HOSPITALIZED. MR. DAVIS SPOKE WITH ARLENE PESSOA, THE ADMINISTRATOR AT THE NURSING HOME, TO FIND OUT WHY HIS MOTHER WAS NOT PROVIDED WITH WATER. MS. PESSOA APOLOGIZED FOR THE INCIDENT, BUT SAID THAT SHE HAS HAD PROBLEMS MAINTAINING PROPER STAFFING LEVELS.

EMTALA

1. THE ANONYMOUS CALLER CLAIMED TO WORK IN THE EMERGENCY ROOM AT MIDSTATE HOSPITAL. THE CALLER STATED THAT ON THE EVENING OF 4/15/08 AN AMBULANCE BROUGHT IN A MIDDLE-AGED BLACK MALE PATIENT WHO WAS BLEEDING FROM THE HEAD AND DISORIENTED. JANE SMITH, THE INTAKE SUPERVISOR, TOLD THE AMBULANCE DRIVER THAT THEY WERE FULL SO THEY WOULD NEED TO TAKE THE TAKE THE PATIENT TO UPTOWN MEDICAL CENTER. AFTER THE AMBULANCE HAD LEFT A NURSE TOLD MS. SMITH THAT THE ER WAS NOT THAT CROWDED. MS. SMITH EXPLAINED THAT THE PATIENT APPEARED TO BE HOMELESS AND THAT THE HOSPITAL ADMINISTRATOR HAS BEEN COMPLAINING ABOUT THE NUMBER OF UNINSURED PATIENTS BEING ADMITTED THROUGH THE EMERGENCY ROOM. THE CALLER STATED THAT ANY PATIENT PRESENTING A HEAD WOUND NORMALLY GETS TOP PRIORITY FOR EVALUATION.

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PRIVATE MEDICARE PLANS

MEDICARE ADVANTAGE PLANS

WHEN A MEDICARE BENEFICIARY ENROLLS IN A MEDICARE ADVANTAGE PLAN, ALL CHARGES FOR SERVICES RENDERED TO THAT BENEFICIARY SHOULD BE SUBMITTED TO AND PROCESSED BY THE PLAN.

THEREFORE, WE WILL HANDLE CALLS DIFFERENTLY FOR BENEFICIARIES IN MEDICARE PRIVATE PLANS THAN WE WOULD FOR BENEFICIARIES WHO ARE IN THE TRADITIONAL MEDICARE FEE-FOR-SERVICE.

THE MAIN MEDICARE ADVANTAGE PLAN TYPES ARE –

HEALTH MAINTENANCE ORGANIZATION (HMO) - WHERE THE BENEFICIARY'S ACCESS TO CARE IS CLOSELY MANAGED; A REFERRAL IS REQUIRED FOR ANY TYPE OF SPECIALIZED CARE.

PREFERRED PROVIDER ORGANIZATION (PPO) - RESTRICTED TO A PARTICULAR REGION, A PPO ALLOWS THE BENEFICIARY TO RECEIVE CARE AT A LOWER COST FROM PARTICIPATING HOSPITALS AND PHYSICIANS; CARE IS AVAILABLE OUTSIDE THE NETWORK FOR A HIGHER COST.

PRIVATE FEE-FOR-SERVICE (PFFS) - A PFFS ALLOWS THE BENEFICIARY TO SEE ANY PROVIDER WHO ACCEPTS THE PLAN'S PAYMENT; THE PLAN, NOT MEDICARE, DECIDES PAYMENT APPROVAL AND BENEFICIARY RESPONSIBILITY.

FURTHER, SOME OF THESE PLANS INCLUDE A PRESCRIPTION DRUG

BENEFIT, ALSO KNOWN AS "MA+PD" PLANS.

ENROLLMENT TACTICS

THE MARKETING OF MEDICARE PRIVATE PLANS CREATES A UNIQUE SET OF PROBLEMS. THE "PROVIDERS" ARE THE INSURANCE COMPANIES THAT UNDERWRITE THE VARIOUS MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLANS, BUT MEDICARE BENEFICIARIES INTERACT WITH INSURANCE AGENTS/BROKERS, SOME OF WHOM WORK DIRECTLY FOR THE PLAN PROVIDER, WHILE OTHERS WORK INDEPENDENTLY (I.E., THEY WILL WRITE POLICIES FOR A VARIETY OF PLANS). IN MOST CASES THE INSURANCE AGENT EARNS A COMMISSION FOR EVERY BENEFICIARY ENROLLED.

MOST OF THE COMPLAINTS COMING INTO THE HOTLINE WILL PROBABLY INVOLVE THE ENROLLMENT TACTICS USED BY PLAY REPRESENTATIVES. A RASH OF WELL-PUBLICIZED ABUSES IN THE EARLY STAGES OF THE MMA CAUSED CMS TO TIGHTEN UP ITS MARKETING GUIDELINES. SPECIFICALLY,

- AGENTS ARE NOT ALLOWED TO REPRESENT THEMSELVES AS BEING "FROM MEDICARE." AGENTS ARE ALLOWED TO STATE THAT THE PLAN IS CONTRACTED WITH MEDICARE BUT THEY ARE NOT ALLOWED TO IMPLY THAT THEY ARE EMPLOYED OR ENDORSED BY MEDICARE.

- AGENTS ARE NOT ALLOWED TO CALL, VISIT, OR IN OTHER WAY CONTACT A BENEFICIARY WITHOUT THE BENEFICIARY'S INVITATION. IN THE COURSE OF A SCHEDULED VISIT, AGENTS SHOULD NOT ASK A BENEFICIARY FOR NAMES OF NEIGHBORS OR FRIENDS WHO MIGHT BE INTERESTED.

- PLANS ARE ALLOWED TO CONDUCT EDUCATIONAL EVENTS BUT ARE NOT ALLOWED TO ENROLL BENEFICIARIES AT SUCH EVENTS.

- PLANS ARE NOT ALLOWED TO MARKET OR CONDUCT SALES ACTIVITIES IN HOSPITALS OR PHYSICIAN OFFICES.

- AGENTS ARE NOT ALLOWED TO COMBINE SALES PRESENTATIONS FOR MEDICARE PRIVATE PLANS WITH THE MARKETING OF LIFE INSURANCE, HOME INSURANCE, OR OTHER NON-HEALTH CARE RELATED PRODUCTS.

- AGENTS ARE REQUIRED TO PROVIDE BENEFICIARIES WITH LITERATURE THAT CLEARLY EXPLAIN THE IMPACT THAT ENROLLMENT WILL HAVE ON MEDICARE COVERAGE.

ANY VIOLATIONS OF THESE GUIDELINES WOULD BE GROUNDS FOR A COMPLAINT. SIMILARLY, YOU WOULD TAKE A COMPLAINT FOR ALLEGATIONS OF OVERTLY DECEPTIVE BEHAVIOR ON THE PART OF A REPRESENTATIVE, SUCH AS ASKING THE BENEFICIARY TO SIGN A FORM "JUST TO SHOW MY SUPERVISOR THAT I WAS HERE," THEN THE BENEFICIARY LEARNS THAT HE WAS ENROLLED IN A MEDICARE ADVANTAGE PLAN.

IF A CALLER ALLEGES THAT A PARTICULAR PLAN IS ENROLLING CLIENTS WITHOUT THE FULL AND INFORMED CONSENT OF THE MEDICARE BENEFICIARY (OR A POWER-OF-ATTORNEY), THIS WOULD BE GROUNDS FOR A COMPLAINT.

IF A CALLER ALLEGES THAT A PLAN ACTIVELY DISSUADES ENROLLMENT BY AGED OR INCAPACITATED MEDICARE BENEFICIARIES, THIS WOULD BE GROUNDS FOR A COMPLAINT.

HOWEVER, IF IT SEEMS THAT A CALLER IS SIMPLY EXPRESSING DISAPPOINTMENT THAT A PLAN DID NOT MEET THE BENEFICIARY'S FULL EXPECTATIONS, YOU WOULD NOT WANT TO TAKE A COMPLAINT.

WHEN YOU TAKE A COMPLAINT FROM A MEDICARE BENEFICIARY WHO CLAIMS TO HAVE BEEN ENROLLED IN A MEDICARE ADVANTAGE PLAN ON THE BASIS OF A DECEPTIVE SOLICITATION, MAKE CLEAR THAT

MAKING A COMPLAINT WITH THE HOTLINE WILL NOT AUTOMATICALLY NULLIFY THE ENROLLMENT. THE BENEFICIARY WILL HAVE TO WORK WITH MEDICARE TO DIS-ENROLL FROM THE PLAN. THE STATE HEALTH INSURANCE ASSISTANCE PROGRAM MIGHT BE ABLE TO ASSIST.

RECOGNIZING A BENEFICIARY ON PRIVATE PLAN

UNFORTUNATELY, MANY BENEFICIARIES (AND THEIR RELATIVES) ARE SO USED TO THE TRADITIONAL MEDICARE PROGRAM THAT THEY ARE NOT FAMILIAR WITH THE TERMINOLOGY, OR MIGHT NOT EVEN BE AWARE OF HOW PRIVATE PLANS WORK.

THEREFORE, A BENEFICIARY MIGHT CAUSE SOME CONFUSION BY INSISTING THAT HE IS CALLING ABOUT A MEDICARE CHARGE, WHILE YOUR FAMILIARITY WITH THE MEDICARE SYSTEM WILL TELL YOU THAT SOMETHING SOUNDS WRONG.

PAY ATTENTION TO SIGNS THAT A BENEFICIARY IS ENROLLED IN A MEDICARE ADVANTAGE PLAN:

- HE MIGHT REFER TO HIS “PRIMARY CARE PROVIDER,” OR “PLAN DOCTOR,” OR SOME OTHER IDENTIFYING FEATURE OF A MANAGED CARE PLAN;

- SHE MIGHT NAME A “MEDICARE OFFICE” THAT YOU KNOW IS NOT ONE OF THE REGULAR CONTRACTORS — MA PLANS OFTEN CONTAIN THE WORDS “SENIOR,” “GOLD,” “PREMIUM,” “ADVANTAGE,” OR “PLUS”;

- HE MIGHT HAVE A BENEFITS NOTICE THAT DOES NOT CONFORM TO THE MEDICARE SUMMARY NOTICE OR EXPLANATION OF MEDICARE BENEFITS — SOME PLANS DO NOT ISSUE ANY BENEFITS NOTICES AT ALL.

IF YOU HEAR ANY OF THESE CLUES, OR THE CALLER GIVES YOU ANY OTHER REASON TO BELIEVE THAT SHE BELONGS TO A PRIVATE PLAN, ASK HER DIRECTLY.

COMPLAINT SCREENING

YOU WILL HANDLE SITUATIONS DIFFERENTLY THAN YOU WOULD WITH A BENEFICIARY IN TRADITIONAL MEDICARE.

SERVICES NOT RENDERED

IF AN MA PLAN-BENEFICIARY COMPLAINS THAT A PROVIDER IS BILLING FOR A SERVICE NOT RENDERED, REFER THE CALLER TO THE MEDICARE ADVANTAGE PLAN SINCE THE PLAN IS RESPONSIBLE FOR PROCESSING THE CLAIM AND PAYING THE PROVIDER.

MEDICARE BILLED FOR SERVICES

IF AN MA PLAN-BENEFICIARY COMPLAINS THAT A PROVIDER BILLED MEDICARE, RATHER THAN THE PLAN, FOR SERVICES, POINT OUT THAT MEDICARE WILL NOT APPROVE ANY CHARGES FOR A BENEFICIARY WHO HAS OPTED OUT OF TRADITIONAL MEDICARE COVERAGE.

THIS SHOULD BE CLEARLY EXPLAINED IN THE NOTES SECTION OF THE MEDICARE SUMMARY NOTICE.

REFER THE BENEFICIARY BACK TO THE PROVIDER OR TO THE PLAN'S CUSTOMER SERVICE OFFICE TO RESOLVE THE ISSUE.

APPEALS OF PLAN DECISIONS

UNDERSTANDABLY, A CALLER WILL BE QUITE EMOTIONAL IF HE FEELS THAT A PLAN WILL NOT COVER A NECESSARY SERVICE, BUT THIS IS NOT A FRAUD ISSUE.

THE FIRST THING YOU SHOULD DETERMINE IS WHETHER THE

BENEFICIARY HAS EXHAUSTED ALL APPEALS WITH THE PRIVATE PLAN.

LISTEN CAREFULLY TO THE RESPONSE: JUST BECAUSE A CALLER CLAIMS TO HAVE "BEEN ON THE PHONE ALL DAY" DOES NOT MEAN THAT A FORMAL APPEAL WAS FILED.

ALL MEDICARE PRIVATE PLANS MUST PROVIDE WRITTEN GUIDELINES ON HOW TO APPEAL A PLAN DETERMINATION.

IF THE PLAN FAILS TO REVERSE ITS ORIGINAL DECISION ON APPEAL, THE CASE IS THEN AUTOMATICALLY REVIEWED BY THE STATE QUALITY IMPROVEMENT ORGANIZATION.

CALLERS UNWILLING TO DEAL FURTHER WITH THE MEDICARE PRIVATE PLAN SHOULD BE REFERRED DIRECTLY TO THE QIO.

FAILURE TO PROVIDE SERVICES

IF A CALLER ASSERTS THAT A MANAGED CARE PLAN IS NOT PROVIDING HER WITH ANY SERVICES AT ALL — AS OPPOSED TO REJECTING A PARTICULAR SERVICE — ASK THE CALLER TO VERIFY WITH MEDICARE THAT THE BENEFICIARY IS ACTUALLY ENROLLED IN THE PLAN.

IF THE CALLER HAS ALREADY TAKEN THAT STEP, OR IS SIMPLY ADAMANT THAT THE BENEFICIARY IS ENROLLED, TAKE A COMPLAINT.

PROVIDER PARTICIPATION

ALL MEDICARE PRIVATE PLANS PLACE SOME RESTRICTIONS ON THE PROVIDERS THAT A BENEFICIARY MAY USE TO RECEIVE SERVICES. MANAGED CARE PLANS GO FURTHER, REQUIRING BENEFICIARIES TO HAVE A PRIMARY CARE PROVIDER WHO MUST APPROVE ANY REFERRALS FOR SPECIALIZED CARE.

THE ROSTER OF PARTICIPATING PROVIDERS FOR ANY MA PLAN WILL

BE FLUID. IT IS THE BENEFICIARY'S RESPONSIBILITY TO VERIFY THAT A PHYSICIAN OR HOSPITAL PARTICIPATES IN A GIVEN PLAN IF THIS IS A DECIDING FACTOR ON WHETHER OR NOT TO ENROLL.

A PROVIDER MAY CHOOSE TO STOP PARTICIPATING AT ANY TIME.

IT IS NOT A CAUSE FOR COMPLAINT IF A BENEFICIARY LEARNS THAT A PROVIDER DOES NOT PARTICIPATE OR IF A PROVIDER LEAVES THE PLAN AFTER ENROLLMENT.

THE ONLY EXCEPTION WOULD BE IF THE ENROLLING AGENT IS DELIBERATELY DECEPTIVE, E.G., "YOU DON'T NEED TO CALL YOUR DOCTOR, I KNOW THAT DR. JONES IS A PARTICIPATING PROVIDER."

FAILURE TO DIS-ENROLL IN A TIMELY MANNER

A BENEFICIARY CAN LEAVE AN MA PLAN BY INFORMING THE PLAN OR THE SOCIAL SECURITY ADMINISTRATION.

IF A CALLER ALLEGES THAT A PLAN HAS FAILED TO DIS-ENROLL A BENEFICIARY, TRY TO DETERMINE THE BASIS FOR THIS JUDGEMENT.

DID THE CALLER RECEIVE A NOTICE SHOWING THAT MEDICARE DENIED PAYMENT FOR A SERVICE AFTER THE DIS-ENROLLMENT DATE ON THE GROUNDS THAT THE BENEFICIARY IS ENROLLED IN A MANAGED CARE PLAN, OR DID THE BENEFICIARY RECEIVE A MASS MAILING FROM THE PLAN ADDRESSED TO "DEAR MEMBER?"

YOU MIGHT SUGGEST CALLING 1-800-MEDICARE OR LOGGING INTO MyMEDICARE TO VERIFY THE BENEFICIARY'S ENROLLMENT STATUS. IF THE BENEFICIARY IS ENROLLED IN MYMEDICARE.GOV, THIS INFORMATION WILL BE AVAILABLE ONLINE.

IF THE CALLER GIVES CREDIBLE INFORMATION THAT THE PLAN HAS FAILED TO DIS-ENROLL A BENEFICIARY IN A TIMELY MANNER, THIS WOULD BE GROUNDS FOR A COMPLAINT.

ADMINISTRATIVE PROBLEMS

IF A CALLER EXPRESSES AN OVERALL DISSATISFACTION WITH THE LEVEL OF CUSTOMER SERVICE PROVIDED BY A PLAN THAT DOES NOT INDICATE FRAUDULENT ACTIVITY (E.G., IT'S HARD TO GET THROUGH TO A REPRESENTATIVE, THEY'RE SLOW IN PROCESSING CLAIMS, THE ROSTER OF PRIMARY CARE PHYSICIANS CHANGES FREQUENTLY), YOU SHOULD REFER THE CALLER TO THE CMS REGIONAL OFFICE TO EXPRESS THESE CONCERNS.

MEDICARE PART D PLANS

BECAUSE OF THE COMPLEX NATURE OF MEDICARE'S PRESCRIPTION DRUG BENEFIT, CMS OPERATES A SPECIAL CALL CENTER DEDICATED TO RECEIVING CALLS INVOLVING FRAUD AND ABUSE IN THE PART D PROGRAM.

BENEFICIARIES PRESENTING FRAUD AND ADMINISTRATIVE PROBLEMS SPECIFIC TO A STAND-ALONE PART D PLAN SHOULD BE REFERRED TO THE MEDICARE DRUG INTEGRITY CONTRACTOR (MEDIC).

IF THE CALLER IS RELUCTANT TO CALL THE MEDIC, THEN YOU SHOULD SCREEN THE CALL USING THE SAME GENERAL PRINCIPLES OUTLINED ABOVE FOR MEDICARE ADVANTAGE PLANS.

COMPLAINT INFORMATION

WHEN YOU TAKE A COMPLAINT REGARDING A MEDICARE PRIVATE PLAN BENEFICIARY YOU SHOULD GATHER THE SAME INFORMATION ON THE BENEFICIARY (AND CALLER) AS YOU WOULD WITH ANY MEDICARE BENEFICIARY COMPLAINT.

YOU SHOULD CLARIFY PRECISELY WHAT TYPE OF PLAN IS INVOLVED: MA, PDP, OR MA+PD PLAN.

YOU SHOULD SOLICIT THE BENEFICIARY'S IDENTIFICATION NUMBER

WITH THE PLAN — THIS WILL BE DIFFERENT FROM THE MEDICARE NUMBER.

FOR THE SUBJECT INFORMATION, YOU SHOULD COLLECT THE NAME AND ADMINISTRATIVE ADDRESS FOR THE PLAN.

IN MOST CASES THE INDIVIDUAL WHO ENROLLS A BENEFICIARY IN A PLAN WILL BE A LICENSED INSURANCE BROKER WHO MAY WORK AS AN INDEPENDENT AGENT, I.E., HE MAY WRITE POLICIES FOR A NUMBER OF PLANS, OR HE MAY WORK EXCLUSIVELY FOR A PARTICULAR PLAN. EVEN IF THE CALLER'S MAIN CONCERN IS WITH THE CONDUCT OF A PARTICULAR AGENT, YOU SHOULD STILL TRY TO IDENTIFY THE MEDICARE ADVANTAGE PLAN AT ISSUE.

IN ADDITION TO SUMMARIZING DETAILS OF THE SITUATION, YOUR COMMENTS SHOULD EXPLAIN WHAT EFFORTS, IF ANY, THAT THE BENEFICIARY HAD TAKEN TO RESOLVE THE MATTER WITH THE PLAN.

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SAMPLE COMMENTS

1. MR. JONES CALLED ON BEHALF OF HIS MOTHER, MARY JONES. ON 11/16/2008 MR. THOMAS CAME TO HER HOME WITHOUT AN APPOINTMENT. SHE LET HIM IN BECAUSE HE SAID THAT MEDICARE HAD SENT HIM. HE LEFT HER HIS CARD AND SOME BROCHURES WHICH HE SAID EXPLAINED SOME NEW BENEFITS SHE WAS ELIGIBLE FOR. HIS MOTHER DOES NOT REMEMBER SIGNING ANYTHING. A FEW DAYS LATER SHE RECEIVED A MEMBERSHIP CARD (ID #: NW876543M) AND WELCOME PACKET FROM NEW HORIZONS, A MEDICARE ADVANTAGE PLAN. WHEN MR. JONES CALLED NEW HORIZONS TO COMPLAIN HE WAS TOLD THAT HIS MOTHER PROBABLY JUST FORGOT THAT SHE SIGNED UP.

2. MR. SMITH IS A MEMBER OF NEW HORIZONS MEDICARE ADVANTAGE PLAN (ID#: NW2345678O). HE SPECIFICALLY CHOSE

THIS PLAN BECAUSE HIS PERSONAL PHYSICIAN, DR. TIQUAR GUPTA (305-555-5555) PARTICIPATED. DR. GUPTA JUST INFORMED MR. SMITH THAT HE WAS GOING TO WITHDRAW FROM THIS PLAN BECAUSE NEW HORIZONS HAD NOT PROCESSED ANY OF THE CLAIMS HE HAD SUBMITTED FOR SEVERAL MONTHS AND HE CAN NEVER REACH ANYONE TO DISCUSS IT. WHEN MR. SMITH CALLED THE BENEFICIARY SERVICE LINE IT TOOK OVER AN HOUR TO GET THROUGH AND "SUSAN" COULD NOT EXPLAIN WHY HIS BILLS WERE NOT BEING PAID.

3. MR. JONES IS A LICENSED INSURANCE BROKER WHO IS EMPLOYED BY INDIANA SAFETY NET. INDIANA SAFETY NET MARKETS A WIDE PORTFOLIO OF INSURANCE PRODUCTS, INCLUDING MEDIGAP AND MEDICARE ADVANTAGE PLANS. IN THE WEEKLY PROGRESS MEETING HELD ON 10/1/07 THE SALES MANAGER, JOSEPH WILD, TOLD THE STAFF THAT WHENEVER THEY ARRANGE AN APPOINTMENT WITH A MEDICARE BENEFICIARY FOR ANY REASON THEY ARE SUPPOSED TO PUSH THE MEDICARE ADVANTAGE PLANS BECAUSE THE COMMISSION IS SO HIGH. THERE HAVE BEEN INSTANCES WHEN MR. JONES HAS SHOWN UP FOR APPOINTMENTS ARRANGED BY THE OFFICE STAFF IN WHICH HE WAS TOLD THE CLIENT WAS INTERESTED IN A MEDICARE ADVANTAGE PLAN BUT WHEN HE ARRIVED LEARNED THAT THE CLIENT HAD ACTUALLY CALLED ABOUT ANNUITIES OR LIFE INSURANCE. MR. JONES UNDERSTANDS THAT MEDICARE GUIDELINES FORBID USING OTHER PRODUCTS AS A LURE TO MARKET MEDICARE PRIVATE PLANS.

4. THE ANONYMOUS CALLER CLAIMED TO BE AN EMPLOYEE OF DRUGMART, A PHARMACEUTICAL BENEFITS MANAGER FOR SEVERAL MEDICARE PART D PLANS. THE CALLER ALLEGED THAT DRUGMART HAS ENTERED INTO A KICKBACK ARRANGEMENT WITH THE PHARMACEUTICAL COMPANY WEMAKEDRUGS. DRUGMART HAS AGREED NOT TO SUBSTITUTE GENERIC MEDICATIONS WHEN PHYSICIANS PRESCRIBE SLOWITDOWN, A BLOOD PRESSURE MEDICATION, EVEN THOUGH EFFECTIVE GENERICS ARE AVAILABLE. IN RETURN, WEMAKEDRUGS WILL OFFER DISCOUNTS ON A NEW ANTIDEPRESSANT TO DRUGMART'S CLIENTS. THE CALLER STATED

THAT HE HEARD THE TERMS OF THE AGREEMENT FROM ED WOOD, MIDWEST MARKETING MANAGER FOR DRUGMART.

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HEALTHCARE EMPLOYEES

YOU SHOULD HANDLE EVERY CALL IN A PROFESSIONAL MANNER, BUT YOU MUST RECOGNIZE THAT ANY CALL FROM A HEALTHCARE EMPLOYEE HAS THE POTENTIAL TO YIELD CRITICAL INFORMATION.

FOR OUR PURPOSES, WE WILL DEFINE THE TERM "HEALTHCARE EMPLOYEES" TO INCLUDE ALL PERSONS IN SOME WAY EMPLOYED IN THE HEALTHCARE FIELD, FROM PRACTITIONERS (PHYSICIANS, NURSES, THERAPISTS, TECHNICIANS) WHO DELIVER HANDS-ON CARE TO THOSE WHO OWN, MANAGE OR PROVIDE ADMINISTRATIVE SUPPORT TO HEALTHCARE ENTITIES.

A HEALTHCARE EMPLOYEE MAY BE REPORTING ON HIS OWN ENTERPRISE OR ANOTHER PROVIDER.

HEALTHCARE EMPLOYEES ARE GENERALLY KNOWLEDGEABLE ABOUT MEDICARE REGULATIONS AND STANDARD PRACTICES. MOREOVER, AS INSIDERS, THEY WILL OFTEN KNOW THE INTENTIONS OF THE PARTIES BILLING MEDICARE.

COMPLAINTS FROM HEALTHCARE EMPLOYEES ARE OFTEN REFERRED TO A REGIONAL OFFICE OF INVESTIGATIONS AS A POTENTIAL CRIMINAL MATTER.

IS IT A HEALTHCARE EMPLOYEE?

SOME HEALTHCARE EMPLOYEES WILL QUICKLY IDENTIFY THEMSELVES, BUT OTHERS WILL BE UNDERSTANDABLY NERVOUS ABOUT MAKING A REPORT:

- THEY MAY BE RISKING THEIR CURRENT JOB OR THEIR FUTURE PROSPECTS BY CALLING US;

- THEY MAY BE AFRAID OF RETALIATION IF IT WERE TO BECOME KNOWN THAT THEY MADE A REPORT;

- SOME MAY FEAR THAT THEY ARE EXPOSING THEMSELVES TO INVESTIGATION BECAUSE OF THEIR CONNECTION TO THE WRONGDOING.

AS A RESULT, SOME EMPLOYEES MAY BE RELUCTANT TO REVEAL THEIR POSITION WHEN THEY CALL.

A BENEFICIARY WILL USUALLY BEGIN THE CONVERSATION BY TALKING ABOUT "THAT LETTER YOU PEOPLE SENT ME."

PAY CAREFUL ATTENTION TO CLUES THAT THE CALLER IS AN INSIDER:

- HE MIGHT START USING HIGHLY TECHNICAL LANGUAGE — PROCEDURE NAMES, BILLING CODES, FORM NUMBERS, JARGON — AND EXPECT THAT YOU UNDERSTAND;

- SHE MIGHT MENTION THAT SHE LEARNED OF OUR NUMBER THROUGH AN ASSOCIATION NEWSLETTER OR CONFERENCE;

- A COMMON PRACTICE OF HEALTHCARE EMPLOYEES IS TO BEGIN WITH A QUESTION, SUCH AS, "IS IT OKAY FOR OXYGEN SUPPLIERS TO BE CERTIFYING THEIR OWN PATIENTS FOR HOME OXYGEN THERAPY?" OFTEN THE CALLER'S TONE, OR SOMETIMES THE NATURE OF THE QUESTION ITSELF, WILL MAKE CLEAR THAT HE SUSPECTS WRONGDOING BUT WANTS SOME KIND OF REASSURANCE BEFORE MAKING AN ALLEGATION.

IF YOU DETECT ONE OF THESE CLUES, OR HAVE OTHER REASON TO SUSPECT THE CALLER IS A HEALTHCARE EMPLOYEE, ASK HIM THIS

DIRECTLY — YOUR TONE WILL BE VERY IMPORTANT, SINCE YOUR GOAL IS TO CLARIFY THE SITUATION, NOT SCARE AWAY THE CALLER.

THE ROLE OF THE PHYSICIAN

BY LAW MEDICARE WILL ONLY COVER SERVICES THAT ARE MEDICALLY NECESSARY. TO ENFORCE THIS STANDARD MEDICARE RELIES ON PHYSICIANS, AS DULY LICENSED TO PERFORM MEDICINE BY THEIR RESPECTIVE STATES, TO SERVE AS GATEKEEPERS FOR SUPPLIES AND TREATMENT.

FOR EPISODES IN WHICH PHYSICIANS PROVIDE HANDS-ON CARE, IT IS ASSUMED THAT THEY WILL RENDER ONLY THOSE SERVICES DICTATED BY THE PATIENT'S CONDITION. BUT MEDICARE ALSO PAYS NON-PHYSICIAN PRACTITIONERS AND ENTITIES FOR EQUIPMENT, LABORATORY TESTING, IMAGING, SUPPLIES, HOME CARE, THERAPY, INPATIENT CARE, REHABILITATION, EMERGENCY TRANSPORT, AND PRESCRIPTION MEDICATION.

FEE-FOR-SERVICE MEDICARE ALLOWS FOR BENEFICIARIES TO SEE ANY DOCTOR THEY CHOOSE, BUT WILL NOT PAY FOR ANCILLARY SERVICES WITHOUT PHYSICIAN ORDERS. THAT MEANS THAT PHYSICIANS MUST PRESCRIBE, AUTHORIZE, MONITOR, OR, IN SOME CASES, SUPERVISE THE DELIVERY OF THESE NON-PHYSICIAN SERVICES AND SUPPLIES.

IN AN IDEAL SCENARIO, IN THE COURSE OF AN OFFICE VISIT A PHYSICIAN AND HER PATIENT WILL DISCUSS THE NEED FOR A WALKER. THE PHYSICIAN WILL EITHER ORDER THE WALKER FOR THE PATIENT OR WRITE A PRESCRIPTION THAT THE BENEFICIARY CAN TAKE TO ANY SUPPLIER. THE SUPPLIER CAN THEN SUBMIT THE CHARGES TO MEDICARE WITH REASONABLE EXPECTATION OF BEING REIMBURSED AT 80% OF THE MEDICARE FEE-SCHEDULE.

PROVIDERS ARE NOT SUPPOSED TO BE MARKETING THEIR SERVICES DIRECTLY TO MEDICARE BENEFICIARIES. THEY MAY ADVERTISE IN A GENERAL WAY THAT THEIR SERVICES AND PRODUCTS ARE OFTEN

COVERED BY MEDICARE. THEY MAY OFFER IN A GENERAL WAY TO "WORK WITH YOUR PHYSICIAN." BUT THEY ARE CROSSING A LINE WHEN THEY CONTACT A BENEFICIARY DIRECTLY AND PROMISE THAT MEDICARE WILL COVER A SERVICE. THEY ARE CROSSING A LINE WHEN THEY SUBMIT COMPLETED AUTHORIZATION FORMS TO A PHYSICIAN FOR HIS SIGNATURE "SO THEY CAN BILL MEDICARE." SO TAKING THE SAME SCENARIO AS ABOVE, IT WOULD BE A VIOLATION FOR AN EQUIPMENT SUPPLIER TO CALL A BENEFICIARY AND ASK HER IF SHE WANTS A WALKER.

UNDERSTANDING THIS DYNAMIC IS IMPORTANT BECAUSE IT LIES AT THE ROOT OF MANY OF THE SCENARIOS YOU WILL HEAR INVOLVING FRAUDULENT ACTIVITY BY HEALTHCARE PROVIDERS.

YOU MAY HEAR COMPLAINTS ABOUT ENTITIES THAT CIRCUMVENT THE NEED FOR PHYSICIAN AUTHORIZATION BY FORGING PHYSICIAN SIGNATURES OR IGNORING THE DOCUMENTATION ALTOGETHER. YOU MAY ALSO HEAR ABOUT PHYSICIANS WHO RECEIVE KICKBACKS FOR SIGNING OFF ON EQUIPMENT ORDERS, REGARDLESS OF MEDICAL NECESSITY.

KICKBACKS

FEDERAL LAW STRICTLY FORBIDS ANY FINANCIAL INDUCEMENTS FOR THE REFERRAL OF SERVICES OR SUPPLIES THAT ARE COVERED BY FEDERAL HEALTH INSURANCE PROGRAMS. MANY OF THE CALLS YOU RECEIVE FROM HEALTHCARE EMPLOYEES WILL INVOLVE SOME KIND OF KICKBACK ARRANGEMENT.

IN SOME INSTANCES THE NATURE OF THE KICKBACK WILL BE OBVIOUS; FOR EXAMPLE, A DOCTOR RECEIVES $50.00 FOR EVERY PATIENT HE REFERS TO AN OXYGEN SUPPLIER.

BUT AN INDUCEMENT CAN BE ANYTHING OF VALUE, NOT JUST STRAIGHTFORWARD CASH PAYMENTS, SO MOST KICKBACK ARRANGEMENTS ARE MORE SUBTLE. HERE ARE SOME EXAMPLES:

- CREATING A SHAM "MEDICAL DIRECTOR" OR "CONSULTANT" POSITION FOR A PHYSICIAN THAT ENTAILS NO WORK WITH THE EXPECTATION THAT THE PHYSICIAN WILL REFER TO THAT PROVIDER EXCLUSIVELY

- PAYING THE SALARY OF A NURSE OR STAFF MEMBER IN A PHYSICIAN'S OFFICE (WHO IS OFTEN RESPONSIBLE FOR ARRANGING REFERRALS)

- PROVIDING OFFICE SPACE OR EQUIPMENT RENTALS AT REDUCED COST IN RETURN FOR REFERRALS

- WAIVING MEDICARE CALCULATED COST-SHARING FOR ALL BENEFICIARIES (PROVIDERS MAY WAIVE COST-SHARING FOR INDIVIDUALS BASED ON FINANCIAL HARDSHIP).

AS A RULE YOU SHOULD BE SUSPICIOUS OF ANY SITUATIONS WHERE A PROVIDER REFERS ALL BENEFICIARIES FOR A PARTICULAR SERVICE TO ONE PROVIDER EXCLUSIVELY. THERE COULD BE A LEGITIMATE REASON FOR THIS – A PHYSICIAN MAY HAVE TRUST IN ONE EQUIPMENT-PROVIDER BASED ON EXPERIENCE – BUT IT CREATES THE APPEARANCE OF A KICKBACK ARRANGEMENT.

IT TAKES TWO PARTIES TO ENGAGE IN A KICKBACK ARRANGEMENT SO WHEN YOU ENTER A COMPLAINT RECORD YOU SHOULD TRY TO GET INFORMATION BOTH ON THOSE OFFERING AND ON THOSE ACCEPTING THE INDUCEMENT.

AN OFFSHOOT OF OVERT KICKBACK ARRANGEMENTS INVOLVE INSTANCES WHERE PHYSICIANS REFER PATIENTS FOR ANCILLARY SERVICES TO A PROVIDER THAT IS WHOLLY OR PARTIALLY OWNED BY THAT SAME PHYSICIAN. AS FAR A MEDICARE IS CONCERNED THE THREAT LOOMS THAT FINANCIAL CONSIDERATIONS MAY INFLUENCE THE PHYSICIAN TO ORDER UNNECESSARY SERVICES.

PHYSICIANS ARE FORBIDDEN FROM REFERING SERVICES TO A FACILITY THAT THEY OWN; THIS IS THE SUBSTANCE OF THE SO-CALLED "STARK LAWS." THERE ARE NUMEROUS LEGAL EXCEPTIONS, BUT YOU SHOULD ENTER A COMPLAINT RECORD ON IRIS WHEN SELF-REFERRAL IS ALLEGED.

A RECENT TREND IN THE MEDICAL INDUSTRY IS FOR HOSPITALS AND PHYSICIAN PARTNERS TO INVEST JOINTLY IN SPECIALIZED FACILITIES. OIG HAS FOUND THAT SOME OF THESE AGREEMENTS CONSTITUTE KICKBACKS BECAUSE THEY ARE STRUCTURED IN SUCH A WAY THAT PHYSICIAN RETURNS HINGE ON THE NUMBER OF REFERRALS THEY MAKE TO THE FACILITY. FOR THIS REASON, MANY PARTIES CONSIDERING SUCH A PARTNERSHIP SUBMIT THE BUSINESS PLAN TO OCIG FOR AN ADVISORY OPINION BEFORE FINALIZING THE ARRANGEMENT.

HOSPITALIZATION CREATES THE POTENTIAL FOR KICKBACK/SELF-REFERRAL ARRANGEMENTS BECAUSE DISCHARGED PATIENTS OFTEN REQUIRE THERAPY OR EQUIPMENT SUBSEQUENT TO THEIR STAY. HOSPITALS ARE REQUIRED TO MAINTAIN A LIST OF AVAILABLE SERVICE PROVIDERS IN THE AREA SO THAT MEDICARE BENEFICIARIES HAVE ALTERNATIVES TO A PROVIDER SUGGESTED BY THE HOSPITAL DISCHARGE PLANNERS.

EXCLUSIONS

ONE OF THE MOST SEVERE PENALTIES THAT A HEALTHCARE PROVIDER CAN RECEIVE IS TO BE EXCLUDED FROM FEDERAL HEALTH INSURANCE PROGRAMS, GIVEN THE NUMBER OF CITIZENS WHO RELY ON THESE PROGRAMS. THIS OCCURS WHEN PROVIDERS ARE CONVICTED OF CERTAIN HEALTHCARE-RELATED CRIMES OR HAVE THEIR LICENSES REVOKED BY STATE REGULATING AUTHORITIES. (FOR THIS REASON, MANY A HEALTHCARE PROVIDER UNDER INVESTIGATION MAY AGREE TO PAY A LARGE FINE TO AVOID BEING EXCLUDED.)

OIG MAINTAINS THE LIST OF EXCLUDED INDIVIDUALS AND ENTITIES

(LEIE) WHICH CAN BE SEARCHED ONLINE OR DOWNLOADED. HEALTHCARE PROVIDERS WHO PARTICIPATE IN FEDERAL HEALTH INSURANCE PROGRAMS ARE REQUIRED TO VERIFY THAT NONE OF THEIR EMPLOYEES APPEAR ON THE LEIE. FOR EXAMPLE, IF A HOSPITAL WERE TO HIRE A NURSE WHO HAS BEEN EXCLUDED OR BUY INSTRUMENTS FROM A SUPPLIER THAT HAS BEEN EXCLUDED THEN THE HOSPITAL WOULD RENDER ITSELF INELIGIBLE FOR MEDICARE PAYMENTS.

QUESTIONS OR COMPLAINTS ABOUT ACCESSING THE ONLINE LEIE TOOLS AS WELL AS COMPLAINTS FROM PROVIDERS ABOUT BEING EXCLUDED SHOULD BE REFERRED TO THE LEIE STAFF.

CORPORATE INTEGRITY AGREEMENTS

IN ORDER TO AVOID EXCLUSION FROM FEDERAL HEALTH INSURANCE PROGRAMS SOME PROVIDERS WILL AGREE VOLUNTARILY TO ENTER A CORPORATE INTEGRITY AGREEMENT (CIA). MOST CIA'S REQUIRE THAT THE PROVIDER ADOPT A COMPLIANCE PROGRAM DESIGNED TO PREVENT REOCCURENCE OF THE TRANSGRESSIONS THAT BROUGHT THE PROVIDER TO THE ATTENTION OF THE CIA.

IF IN THE COURSE OF EXPLAINING A COMPLAINT A SOURCE STATES THAT THE PROVIDER HAS ENTERED A CIA THEN YOU SHOULD MENTION THIS IN YOUR COMMENTS.

IF THE SOURCE MAKES A STATEMENT TO THE EFFECT, "THIS HOSPITAL HAS BEEN IN TROUBLE WITH OIG BEFORE," THEN YOU SHOULD ASK SPECIFICALLY IF IT IS SUBJECT TO A CIA.

"WHAT IS MY CULPABILITY?"

OFTEN A CALLER WILL EXPLAIN THAT A FORMER OR CURRENT CO-WORKER – IT COULD BE A SUPERVISOR, ASSOCIATE, OR SUBORDINATE – HAS BEEN INVOLVED IN QUESTIONABLE PRACTICES AND WANTS TO KNOW IF SHE CAN BE HELD LIABLE IF ANY CRIMINAL

OR CIVIL PENALTIES ARE ASSESSED. FOR EXAMPLE, AN EMPLOYEE OF A BILLING OFFICE MIGHT SAY THAT SHE WAS INSTRUCTED TO CODE A SERVICE IN A CERTAIN WAY, ONLY TO LEARN LATER THAT THIS WAS INAPPROPRIATE. OR A PHYSICIAN MIGHT REPORT THAT ONE OF HER COLLEAGUES HAS BEEN PRESCRIBING UNNECESSARY TESTS AND WANTS TO KNOW IF ALL THE PHYSICIANS IN THE PRACTICE ARE CULPABLE. SIMILARLY, SOME CALLERS WILL CALL TO ASK IF THEY ARE OBLIGATED BY OIG RULES TO REPORT ANY VIOLATIONS THEY OBSERVE.

OBVIOUSLY, YOU SHOULD NEVER OFFER LEGAL ADVICE TO A CALLER. LISTEN TO THE CALLER'S TONE: IF THE CALLER SEEMS GENUINELY CONCERNED ABOUT HER LEGAL POSITION, YOU SHOULD SUGGEST THAT SHE SPEAK WITH AN ATTORNEY. YOU MIGHT SUGGEST A PROFESSIONAL ASSOCIATION AS ANOTHER SOURCE OF LEGAL ADVICE. YOU CAN DIRECT THE CALLER TO THE OIG WEBSITE FOR INFORMATION ON THE VOLUNTARY DISCLOSURE PROGRAM.

IN THE COURSE OF THE CALL YOU SHOULD EXPLAIN THE HOTLINE'S FUNCTION AND GIVE THE CALLER THE OPPORTUNITY TO ENTER AN ALLEGATION. BUT IN DOING SO YOU MUST AVOID GIVING THE IMPRESSION THAT YOU ARE EXTENDING SOME DEGREE OF IMMUNITY IN RETURN FOR REVEALING TO US WHAT SHE KNOWS.

SELF-DISCLOSURE

IN THE INTEREST OF PRESERVING THE MEDICARE TRUST FUND THE OIG HAS EXTENDED TO HEALTHCARE PROVIDERS WHO HAVE UNCOVERED IMPROPER MEDICARE PAYMENTS AS A RESULT OF INTERNAL REVIEWS THE OPPORTUNITY TO AVOID CRIMINAL PENALTIES AND EXCLUSION BY SELF-DISCLOSING THE ACTIVITY.

OIG HAS ESTABLISHED PROTOCOLS FOR MAKING A SELF-DISCLOSURE. CALLING THE HOTLINE DOES NOT CONSTITUTE SELF-DISCLOSURE.

IF A CALLER INDICATES THIS INTENT, REFER HIM TO THE

PROTOCOLS ON THE OIG WEB SITE.

TYPES OF COMPLAINTS

ALTHOUGH THERE MAY BE MANY COMPLICATING FACTORS, AT ROOT YOU ARE LOOKING FOR ONE OF THESE CONDITIONS:

- A PROVIDER IS BILLING MEDICARE FOR SERVICES THAT ARE NOT BEING RENDERED
- A PROVIDER IS BILLING MEDICARE FOR SERVICES THAT ARE NOT NECESSARY
- A PROVIDER IS SUBMITTING CPT CODES INDICATING A HIGHER LEVEL OF SERVICE THAN WAS PERFORMED, I.E., UPCODING
- A PROVIDER IS BILLING UNDER SEVERAL CPT CODES FOR A SERVICE THAT IS PROPERLY BILLED UNDER ONE CODE, I.E, UNBUNDLING
- A PROVIDER IS BILLING MEDICARE FOR SERVICES OR SUPPLIES THAT WERE NOT PROPERLY AUTHORIZED BY A PHYSICIAN
- A PROVIDER IS BILLING FOR THE SERVICES OF PERSONNEL WHO DO NOT HAVE THE PROPER LICENSE OR CREDENTIALS
- A PROVIDER IS BILLING MEDICARE FOR SERVICES THAT ARE NOT PROPERLY DOCUMENTED
- A PROVIDER IS DIRECTLY SOLICITING BENEFICIARIES
- A PROVIDER IS USING IMPROPER INDUCEMENTS TO GENERATE REFERRALS, I.E., KICKBACKS
- A PROVIDER IS SOLICITING BENEFICIARIES DIRECTLY

- A PROVIDER IS REFUSING TO REFUND OVERPAYMENTS, EITHER TO BENEFICIARIES OR TO MEDICARE

- A PROVIDER HAS HIRED OR IS DOING BUSINESS WITH AN INDIVIDUAL WHO HAS BEEN PLACED ON THE OIG LIST OF EXCLUDED INDIVIDUALS AND ENTITIES

- A PROVIDER WHO IS ON THE OIG LIST OF EXCLUDED INDIVIDUALS AND ENTITIES IS PARTICIPATING IN MEDICARE USING SOMEONE ELSE'S CREDENTIALS OR PROVIDER NUMBER.

AS A RULE YOU SHOULD OFFER TO TAKE AN ALLEGATION IN ANY INSTANCE WHEN A HEALTHCARE EMPLOYEE ARTICULATES AN INTELLIGIBLE COMPLAINT. ONE EXCEPTION THAT YOU SHOULD BE WARY OF IS WHEN A CALLER TRIES TO REPORT A PRIVATE DISPUTE COMPANIES AS MEDICARE FRAUD. FOR EXAMPLE, A FORMER ADMINISTRATOR OF A HOME HEALTH AGENCY MIGHT CALL TO COMPLAIN THAT SHE WAS UNJUSTLY TERMINATED OR DID NOT RECEIVE HER FULL PAYMENT. SHE WILL ARGUE THAT BECAUSE THE COMPANY RECEIVES PAYMENT FROM MEDICARE THESE ISSUES CONSTITUTE POTENTIAL MEDICARE FRAUD. YOU WILL HAVE TO EXPLAIN TO SUCH CALLERS THAT IT IS NOT THE ROLE OF THE OIG TO TAKE SIDES IN LABOR DISPUTES OR CIVIL PROCEEDINGS. IT MAY BE THAT A DISGRUNTLED FORMER EMPLOYEE WILL HAVE INFORMATION ON HOW HER EMPLOYER DEFRAUDED MEDICARE, BUT YOU SHOULD NOT TAKE A COMPLAINT OVER A PRIVATE ISSUE.

COMPLAINT INFORMATION

IF YOUR BEST JUDGEMENT TELLS YOU THAT A HEALTHCARE PROVIDER HAS A COMPLAINT OF FRAUD AGAINST THE MEDICARE PROGRAM, OFFER TO TAKE A COMPLAINT.

THE RANGE OF POSSIBLE COMPLAINTS IS MUCH GREATER WITH EMPLOYEES THAN WITH BENEFICIARIES, BUT THERE ARE STILL SOME GENERAL PRINCIPLES YOU SHOULD FOLLOW IN COLLECTING INFORMATION FOR SUCH COMPLAINTS.

DO NOT BE SATISFIED WITH A DECLARATION SUCH AS, "THERE'S SO MUCH FRAUD, ALL SOMEONE HAS TO DO IS LOOK AT THE BOOKS AND IT WILL BE CLEAR," OR "THEY'VE BEEN IN TROUBLE BEFORE."

ASK SPECIFIC QUESTIONS:

- ARE DOCUMENTS BEING FORGED?
- ARE PATIENTS NOT MEETING MEDICARE CRITERIA FOR MEDICAL NECESSITY?
- IS SOMEONE GETTING KICKBACKS?
- IF THEY ALLEGE THAT A DOCTOR IS "UPCODING" HIS SERVICES FOR MEDICARE PATIENTS, ASK WHAT SPECIFIC CODES ARE BEING ABUSED?
- IF THE ALLEGATION IS THAT A DOCTOR IS ORDERING UNNECESSARY TESTS, ASK WHAT TESTS ARE BEING ORDERED?

BECAUSE HEALTHCARE EMPLOYEES HAVE A SPECIALIZED KNOWLEDGE, IT IS INEVITABLE THAT YOU WILL HAVE CONVERSATIONS IN WHICH YOU FEEL INTIMIDATED BECAUSE YOU DO NOT KNOW AS MUCH AS THE CALLER.

WHENEVER THE CALLER USES TERMINOLOGY YOU DO NOT UNDERSTAND, ASK HIM TO EXPLAIN IT (AND SPELL IT, IF NECESSARY).

IF YOU DO NOT UNDERSTAND SOMETHING THE CALLER TELLS YOU, YOU WILL BE UNABLE TO MAKE A DECISION ABOUT WHETHER TO TAKE A COMPLAINT.

WHENEVER YOU TAKE A COMPLAINT, YOU WILL BE EXPECTED TO SUMMARIZE THE SITUATION WHEN WRITING UP THE

COMPLAINT AND TO BE PREPARED TO ANSWER QUESTIONS ABOUT THE COMPLAINT — THIS WILL BE DIFFICULT IF YOU DID NOT UNDERSTAND EVERYTHING THE CALLER TOLD YOU.

TRY TO FIND OUT HOW LONG THE ALLEGED WRONGDOING HAS BEEN TAKING PLACE.

ASK IF THE CALLER HAS BROUGHT THE SITUATION TO THE ATTENTION OF ANYONE WITHIN THE ENTITY INVOLVED. AND IF SO, WHAT WAS THE OUTCOME?

ASK WHAT OFFICIALS (NAMES AND TITLES) WITHIN THE COMPANY ARE MOST RESPONSIBLE FOR THE ACTIVITY IN QUESTION.

ASK HOW THE PROVIDER HAS BEEN ABLE TO CONCEAL THE ACTIVITY.

FIND OUT IF THE CALLER HAS ANY DOCUMENTATION TO SUPPORT HIS ALLEGATIONS. IF YES, NOTE IN YOUR COMMENTS WHAT TYPE OF DOCUMENTATION THE CALLER HAS.

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SAMPLE COMMENTS

1. MS. JONES IDENTIFIED HERSELF AS A HOME HEALTH AIDE FOR ACME HOME HEALTH. SHE ALLEGES THAT MANY OF THIS AGENCY'S MEDICARE PATIENTS ARE NOT HOMEBOUND. BUT WHEN A NURSE OR AIDE REPORTS THIS, HE OR SHE IS TOLD TO CONTINUE SEEING THE PATIENT AND TO ENTER IN THE PATIENT NOTES THAT THE PATIENT IS HOMEBOUND. SHE WAS ABLE TO PROVIDE THE FOLLOWING NAMES OF PATIENTS WHO ARE NOT HOME BOUND: JOE JOHNSON (123-45-6789A), SAMMY SMITH (234-56-7891A), WILLIE WILLIAMS (345-67-8912A). SHE FURTHER ALLEGES THAT MANY OF THE PATIENTS DO NOT HAVE A CURRENT FORM 485 (CERTIFICATE OF MEDICAL NECESSITY) ON FILE. SHE STATES THAT JANE DOE, THE

OWNER-ADMINISTRATOR, IS AWARE OF THESE PROBLEMS. SHE HAS THREATENED TO FIRE SEVERAL EMPLOYEES WHO HAVE COMPLAINED ABOUT THESE PROBLEMS.

2. THE ANONYMOUS CALLER IDENTIFIED HIMSELF AS A FORMER EMPLOYEE OF ACME HOME HEALTH. HE ALLEGES THAT JANE DOE, THE OWNER-ADMINISTRATOR, IS SENDING MARKETERS TO SENIOR CENTERS AND DRUG TREATMENT FACILITIES TO RECRUIT MEDICARE BENEFICIARIES AS PATIENTS. POTENTIAL PATIENTS ARE OFFERED $100 IF THEY WILL GO WITH THE MARKETERS TO A CLINIC WITH THE PROMISE OF MORE PAYMENTS IF THEY ENROLL IN HOME HEALTH CARE. THE RECRUITS ARE TAKEN TO DOWNTOWN DIAGNOSTIC CLINIC, WHICH RECEIVES PAYMENT FOR EVERY PATIENT CERTIFIED. ACME HOME HEALTH SENDS OUT NURSES TO DO AN INITIAL ASSESSMENT, BUT FEW VISITS ARE ACTUALLY MADE. THE CALLER REPORTED THAT MANY OF THE RECRUITS HAVE ADDICTION OR MENTAL HEALTH PROBLEMS BUT NO NEED FOR SKILLED NURSING OR PHYSICAL THERAPY.

3. MS. SMITH IDENTIFIED HERSELF AS THE BILLING CLERK FOR CARDIAC CARE ASSOCIATES, A PRACTICE OF 3 CARDIO-PULMONARY SPECIALISTS. SHE HAS WORKED THERE FOR 18 MONTHS. SHE ALLEGES THAT SHE HAS BEEN INSTRUCTED TO FALSIFY THE DIAGNOSIS CODES WHEN SUBMITTING MEDICARE BILLING. THE MOST COMMON PRACTICE IS TO ENTER THE CODE FOR MILD CHEST PAIN WHEN THIS IS NOT INDICATED ON THE PHYSICIAN'S NOTES. MS. SMITH WAS TOLD THAT SHE MUST DO THIS, OTHERWISE MEDICARE WILL NOT PAY FOR CERTAIN SERVICES, SUCH AS STRESS TESTS. SHE ESTIMATED THAT THIS IS DONE FOR 10-15 PATIENTS PER WEEK. MS. SMITH INDICATED THAT SHE HAS COPIES OF NUMEROUS PHYSICIAN NOTES WHICH WOULD INDICATE THE PATIENTS' ACTUAL CONDITIONS.

4. THE ANONYMOUS CALLER ALLEGES THAT A KICKBACK ARRANGEMENT EXISTS BETWEEN CITY HOSPITAL AND ACME HOME HEALTH. THE DISCHARGE PLANNERS AT CITY HOSPITAL ARE ALL EMPLOYEES OF ACME HOME HEALTH. ALL PATIENTS DISCHARGED FROM THE HOSPITAL WHO ARE IN NEED OF HOME HEALTH CARE ARE AUTOMATICALLY REFERRED TO ACME HOME HEALTH. PATIENTS WHO REQUEST TO BE REFERRED TO DIFFERENT AGENCIES ARE TOLD THAT THEY MUST GO TO ACME TO INSURE CONTINUITY OF CARE. THE CALLER ADDS THAT DR. ALLAN ANDERSON, WHO IS THE MEDICAL DIRECTOR OF ACME HOME HEALTH AND IS A MEMBER OF THE BOARD OF DIRECTORS OF CITY HOSPITAL, WAS INSTRUMENTAL IN SETTING UP THIS ARRANGEMENT.

5. THE ANONYMOUS CALLER IDENTIFIED HERSELF AS AN EMPLOYEE OF CITY HOSPITAL. SHE ALLEGES THAT CITY HOSPITAL IS VIOLATING THE "3-DAY RULE." SHE EXPLAINS THAT WHENEVER A MEDICARE PATIENT RECEIVES OUTPATIENT SERVICES WITHIN 3 DAYS OF BEING ADMITTED TO A HOSPITAL, THE SERVICES ARE CONSIDERED PART OF THE INPATIENT COSTS. CITY HOSPITAL, HOWEVER, FREQUENTLY BILLS MEDICARE FOR SUCH SERVICES SEPARATELY FOR PART B OUTPATIENT CHARGES. IN ORDER TO AVOID DETECTION, THE CITY HOSPITAL BILLING OFFICE WILL OFTEN ALTER THE SERVICE DATE OR DIAGNOSIS CODES ON THE CHARGES TO MEDICARE. SHE STATES THAT THIS HAS BEEN GOING ON SINCE NOVEMBER 2007, WHEN MARY SMITH WAS HIRED AS THE NEW DIRECTOR OF FINANCIAL SERVICES.

6. MS. SMITH IDENTIFIED HERSELF AS THE OFFICE MANAGER OF MIDTOWN FAMILY MEDICAL. SHE CALLED IN REGARD TO ONE OF THEIR PATIENTS, MARY BROADWATER (321543987A). MIDTOWN MEDICAL RECEIVED A FAX ON 7/15/08 FROM RIGHT TO YOUR HOME DME REQUESTING A PHYSICIAN SIGNATURE TO ORDER A WALKER, A HEATING PAD, AND DIABETIC SHOE INSERTS FOR MS. BROADWATER. MS. SMITH PULLED MS. BROADWATER'S FILE AND SAW THAT SHE IS NOT DIABETIC AND THERE WAS NOTHING INDICATING THE NEED FOR THE OTHER ITEMS. SHE CALLED RIGHT TO YOUR HOME DME AND WAS TOLD THAT MS. BROADWATER HAD ORDERED THE

SUPPLIES. MS. SMITH THEN CALLED MS. BROADWATER WHO SAID THAT SOMEONE HAD CALLED AND ASKED HER A FEW QUESTIONS ABOUT HER HEALTH AND WHO HER DOCTOR WAS, BUT MS. BROADWATER DENIED ORDERING ANY SUPPLIES.

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CONTRACTS AND GRANTS

NOT ALL OF THE WORK OF THE DEPARTMENT IS CARRIED OUT BY ITS EMPLOYEES — EVERY YEAR THE DEPARTMENT SPENDS BILLIONS OF DOLLARS ON GRANTS AND CONTRACTS.

HHS ISSUES CONTRACTS TO PRIVATE ENTITIES TO PERFORM SOME SEGMENT OF THE DEPARTMENT'S ONGOING OPERATIONS IN ORDER TO KEEP THE SIZE OF THE HHS PERMANENT WORK FORCE TO A MINIMUM. FOR EXAMPLE, IN MOST HHS OFFICES THE SECURITY AND CUSTODIAL FUNCTIONS ARE HANDLED BY OUTSIDE CONTRACTORS.

HHS ISSUES GRANTS TO PRIVATE ENTITIES TO FUND SOME SHORT-TERM INITIATIVE, OR TO SUBSIDIZE THE OPERATIONS OF HHS PARTNER ORGANIZATIONS AT THE STATE OR LOCAL LEVEL. FOR EXAMPLE, THE NATIONAL INSTITUTES OF HEALTH ISSUES GRANTS TO PRIVATE RESEARCHERS TO CONDUCT MEDICAL RESEARCH.

GRANTS AND CONTRACTS ARE SIMILAR IN THAT BOTH INSTANCES:

- THE MONEY IS EARMARKED FOR A SPECIFIC PURPOSE, AS SPECIFIED IN THE GRANT OR CONTRACT

- THE GRANT OR CONTRACT IS AWARDED ON THE BASIS OF A TRANSPARENT, COMPETITIVE PROCESS IN WHICH ALL POTENTIAL APPLICANTS HAVE EQUAL ACCESS (THERE ARE SOME EXCEPTIONS BASED ON CONTRACT/AWARD SIZE AND PROGRAM URGENCY)

- THE RECIPIENT WILL HAVE ATTESTED TO ITS ABILITY TO CARRY OUT THE PARTICULAR FUNCTION (E.G., ACCREDITATION, WORK HISTORY,

REFERENCES)

- THE RECIPIENT WILL BE EXPECTED TO PERFORM THE SERVICES OR DELIVER THE WORK PRODUCT, AS SPECIFIED IN THE GRANT OR CONTRACT

- THE RECIPIENT WILL BE EXPECTED TO ACCOUNT FOR HOW IT HAS SPENT THE MONEY.

COMPLAINT SOURCES

A LIMITED NUMBER OF PEOPLE WILL HAVE INFORMATION ON THE INNER WORKINGS OF GRANTS AND CONTRACTS, SO, HOPEFULLY, CALLERS WISHING TO ALLEGE FRAUD IN THIS AREA WILL BE KNOWLEDGEABLE ABOUT THE AREAS IN QUESTION.

YOU MAY RECEIVE CALLS FROM —

- AN EMPLOYEE OF A CONTRACTOR, WHO IS AWARE OF IMPROPRIETIES IN THE PERFORMANCE OF A HHS CONTRACT

- AN OWNER OF A FIRM REPORTING THAT A RIVAL FIRM RECEIVED AN UNFAIR ADVANTAGE, OR SUPPLIED FALSE INFORMATION, RECEIVING A CONTRACT

- A STATE GOVERNMENT EMPLOYEE WHO IS AWARE THAT HER AGENCY HAS DIVERTED FUNDS FROM A HHS GRANT FOR PURPOSES NOT SPECIFIED IN THE GRANT

- A HHS EMPLOYEE WHO IS AWARE THAT A CONTRACTOR HAS NOT FULFILLED THE TERMS OF ITS CONTRACT (YOU WOULD WANT TO ASK THIS CALLER IF HE HAS REPORTED THE SITUATION TO HIS SUPERVISOR).

OFFICE OF RESEARCH INTEGRITY

THE OFFICE OF RESEARCH INTEGRITY (ORI) IS TASKED WITH MONITORING THE CONDUCT OF RESEARCH SPONSORED BY THE PUBLIC HEALTH SERVICE, WITH THE EXCEPTION OF THE REGULATORY ACTIVITIES OF THE FOOD AND DRUG ADMINISTRATION. THE ORI IS THE PROPER VENUE FOR COMPLAINTS CONCERNING THE **PERFORMANCE** OF RESEARCH GRANTS.

IF A CALLER WERE TO ALLEGE THAT AN NIH OFFICIAL HAD ACCEPTED A BRIBE TO DIRECT A GRANT TO A PARTICULAR APPLICANT, YOU SHOULD TAKE A COMPLAINT.

IF A CALLER WERE TO ALLEGE THAT WHILE PERFORMING RESEARCH FUNDED BY AN NIH GRANT A SCIENTIST HAD FALSIFIED HIS DATA, IMPROPERLY DOCUMENTED HIS METHODOLOGY, OR PLAGIARIZED A COLLEAGUE'S RESEARCH, YOU SHOULD REFER THE CALLER TO ORI.

TYPES OF COMPLAINTS

REVIEW THE SECTIONS ON "HEALTHCARE EMPLOYEE COMPLAINTS" AND "DEPARTMENT EMPLOYEES"

AS WITH ALL EMPLOYEE COMPLAINTS, YOU ARE GOING TO HAVE TO RELY ON THE EXPERTISE OF THE CALLER, BUT AT THE SAME TIME YOU WILL NEED TO WATCH OUT FOR A CALLER WHO IS MAKING AN INQUIRY AS OPPOSED TO AN ALLEGATION; AND/OR A CALLER WHO IS PRESENTING A GRIEVANCE AGAINST HER EMPLOYER THAT DOES NOT AFFECT THE PERFORMANCE OF THE CONTRACT.

THE PRIMARY CRITERION THAT YOU ARE LOOKING FOR IN ORDER TO TAKE A COMPLAINT IS WHETHER THE DEPARTMENT HAS SUFFERED A MONETARY LOSS OR A DECEPTION ON THE PART OF THE CONTRACTOR/GRANTEE HAS VIOLATED THE INTEGRITY OF THE PROCESS, GENERALLY FALLING UNDER ONE OF THE FOLLOWING:

- SUBMITTING FALSE INFORMATION TO RECEIVE A CONTRACT/GRANT
- FAILURE TO PERFORM THE WORK SPECIFIED IN THE CONTRACT/GRANT
- FAILURE TO SUPPLY CONTRACTED SUPPLIES/EQUIPMENT (OR SUPPLYING INFERIOR PRODUCTS)
- HOLDING A CONTRACT/GRANT THAT CREATES A CONFLICT OF INTEREST WITH OTHER BUSINESS CONCERNS OF THE CONTRACTOR/GRANTEE
- SUBMITTING FALSE WORK REPORTS.

POLICY COMPLAINTS

REVIEW THE "POLICY COMPLAINTS" IN THE HHS EMPLOYEE COMPLAINT SECTION.

THESE INSTRUCTIONS APPLY TO HHS GRANTS AND CONTRACTS.

COMPLAINT INFORMATION

REVIEW "COMPLAINTS INFORMATION" IN THE "HEALTHCARE EMPLOYEES" SECTION FOR THE TYPES OF QUESTIONS YOU NEED TO ASK.

IN ADDITION, WHENEVER YOU TAKE A COMPLAINT INVOLVING A HHS GRANT OR CONTRACT YOU SHOULD TRY TO DETERMINE —

- THE HHS OFFICE THAT ISSUED THE CONTRACT (AT A MINIMUM THE OPERATIONAL DIVISION, PREFERABLY THE SUB-AGENCY)
- THE GRANT OR CONTRACT NUMBER

- THE HHS CONTACT PERSON FOR THE GRANT OR CONTRACT.

FAR REPORTING REQUIREMENTS

AS OF DECEMBER 2008 THE FEDERAL ACQUISITIONS REGULATIONS (FAR) COUNCIL HAS IMPOSED A MANDATORY REQUIREMENT ON GOVERNMENT CONTRACTORS TO REPORT FRAUD, WASTE, AND ABUSE AS WELL AS "SIGNIFICANT OVERPAYMENTS" BY THE GOVERNMENT. IF ANY SOURCE INVOKES THIS REQUIREMENT, BY NAME OR IMPLICATION, THEN YOU SHOULD ENTER A COMPLAINT EVEN IF YOUR JUDGMENT TELLS YOU THAT THE ISSUE WOULD NOT NORMALLY FALL WITHIN OIG JURISDICTION – NOTE IN YOUR COMMENTS THAT THE SOURCE MADE REFERENCE TO THE REQUIREMENT.

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SAMPLE COMMENTS

1. MS. POLLARD IDENTIFIED HERSELF AS AN EMPLOYEE OF THE BIOLOGY DEPARTMENT AT VERMONT STATE UNIVERSITY, WHICH RECEIVED A GRANT (#07-054444-NIEHS) FROM THE NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES TO STUDY THE IMPACT OF ASBESTOS ON MICE. SHE ALLEGES THAT DR. ED EDWARDS, THE GRANT OFFICER, HAS USED GRANT FUNDS FOR PERSONAL TRAVEL AND TO PURCHASE GIFTS FOR HIS MISTRESS. THIS MONEY HAS BEEN REPORTED ON THE COST REPORT AS "OFFICE EQUIPMENT." SHE FURTHER ALLEGES THAT SHE AND OTHER TECHNICIANS HAVE BEEN ORDERED BY DR. EDWARDS TO FALSIFY THE RESULTS OF CLINICAL TESTS TO DIMINISH THE HARM DONE BY ASBESTOS. MS. POLLARD SUSPECTS THAT THIS IS DONE TO INSURE THE RENEWAL OF THE GRANT IN JULY 2009.

2. THE ANONYMOUS CALLER IDENTIFIED HIMSELF AN EMPLOYEE OF THE EAST SIDE FAMILY CENTER. HE STATES THAT THE CENTER HAS RECEIVED A COMMUNITY DEVELOPMENT GRANT (#06-065555-AC)

FROM THE AGENCY FOR CHILDREN AND FAMILIES TO PROVIDE FREE MEDICAL TREATMENT AND COUNSELING TO THE CHILDREN OF LOW-INCOME FAMILIES. THE CALLER ALLEGES SEVERAL IMPROPRIETIES IN THE CONDUCT OF THE GRANT. ERIC HUNTER, PRESIDENT OF EAST SIDE FAMILY CENTER, HAS MADE THE PROGRAM AVAILABLE TO THE CHILDREN OF FAMILY FRIENDS AND ASSOCIATES WHO DO NOT MEET THE INCOME REQUIREMENTS ESTABLISHED FOR THE PROGRAM. MOREOVER, THE CALLER SUSPECTS THAT MR. HUNTER HAS RECEIVED KICKBACKS FROM WEST SIDE FAMILY PRACTICE, WHICH RECEIVED AN EXCLUSIVE CONTRACT TO PROVIDE THE MEDICAL CARE. THE CALLER STATED THAT JOHN JONES ((202)619-5555) IS THE ACF CONTACT FOR THIS GRANT.

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PUBLIC ASSISTANCE PROGRAMS

THE DEPARTMENT FINANCES VARIOUS PROGRAMS WHICH PROVIDE ASSISTANCE TO THE MOST VULNERABLE SECTORS OF THE POPULATION: THE ELDERLY, CHILDREN, PERSONS WITH DISABILITIES, REFUGEES, LOW-INCOME FAMILIES IN NEED OF TEMPORARY ASSISTANCE.

HHS HEALTH INSURANCE PROGRAMS

BY NOW, YOU SHOULD BE FAMILIAR WITH THE MEDICARE PROGRAM, BUT HHS ALSO ADMINISTERS TWO OTHER INSURANCE PROGRAMS.

MEDICAID - PROVIDES HEALTH INSURANCE TO LOW-INCOME FAMILIES.

MEDICAID IS SUBSIDIZED AT THE FEDERAL LEVEL BUT ADMINISTERED AT THE STATE LEVEL; THE STATES HAVE RATHER WIDE LEEWAY IN DECIDING WHAT THE PROGRAM WILL LOOK LIKE.

SERVICES THAT ARE COVERED IN ONE STATE UNDER MEDICAID MIGHT NOT BE COVERED IN A NEIGHBORING STATE;

SOME STATES COMPEL BENEFICIARIES TO ENROL IN A MANAGED CARE PLAN (WHICH IS OPTIONAL UNDER MEDICARE);

SOME STATES HAVE CREATED UNIQUE NAMES FOR THEIR MEDICAID PROGRAMS — FOR EXAMPLE, BADGERCARE IN WISCONSIN, TENNCARE IN TENNESSEE.

MEDICAID vs. MEDICARE

MANY CALLERS WILL CONFUSE THE MEDICARE AND MEDICAID PROGRAMS.

IN ORDER TO HELP YOU SORT OUT SOME THIS CONFUSION, YOU SHOULD UNDERSTAND POINTS OF SIMILARITY AND DIFFERENCE BETWEEN THE TWO PROGRAMS.

MEDICARE IS NOT INCOME-BASED. ELIGIBILITY IS DETERMINED BY THE SOCIAL SECURITY ADMINSTRATION.	**MEDICAID** IS LIMITED TO THE INDIGENT. ELIGIBILITY IS DETERMINED BY STATE SOCIAL SERVICE AGENCIES. IT IS POSSIBLE TO RECEIVE MEDICARE AND MEDICAID BENEFITS AT THE SAME TIME.
MEDICARE IS FUNDED BY THE FEDERAL GOVERNMENT AND BY BENEFICIARY PAYMENTS – PREMIUMS, DEDUCTIBLES, CO-INSURANCE.	**MEDICAID** IS FUNDED BY THE FEDERAL GOVERNMENT AND BY STATE GOVERNMENTS – BENEFICIARIES SOMETIMES PAY SMALL CO-PAYMENTS FOR SERVICES.
CMS MANAGES **MEDICARE** COVERAGE POLICY NATIONALLY WHILE DETERMINATIONS ABOUT INDIVIDUAL CHARGES ARE MADE BY CMS-CONTRACTED INSURANCE COMPANIES.	**MEDICAID** IS ADMINISTERED BY STATE GOVERNMENTS. COVERAGE VARIES FROM STATE TO STATE. SOME STATES HAVE CREATED NEW NAMES FOR THEIR MEDICARE PROGRAM, E.G., TENNCARE AND BADGERCARE.
MEDICARE BENEFICIARIES HAVE THE OPTION OF REMAINING IN TRADITIONAL MEDICARE, WHICH	MANY STATES COMPELL **MEDICAID** BENEFICIARIES TO RECEIVE SERVICES THROUGH A

ALLOWS FOR WIDE FREEDOM OF CHOICE OF PROVIDERS, OR ENROLLING IN A PRIVATE MEDICARE PLAN, WHICH MAY RESTRICT THEIR POOL OF PROVIDERS.	MANAGED CARE PLAN THAT RESTRICTS THEIR CHOICE OF PROVIDERS.
MEDICARE ONLY COVERS RESTORATIVE CARE AND LIMITED PREVENTATIVE SERVICES.	**MEDICAID** IS MORE COMPREHENSIVE THAN MEDICARE, COVERING PREVENTATIVE SERVICES, PRESCRIPTION DRUGS, PERSONAL CARE, AND NURSING HOME CARE.

IT IS IMPORTANT THAT YOU DO NOT CONFUSE THESE PROGRAMS WHEN SPEAKING TO CALLERS — SOME MEDICARE RECIPIENTS MAY BE INSULTED IF YOU MISTAKENLY SUGGEST THAT THEY ARE ON MEDICAID.

AS NOTED ABOVE, MEDICAID COVERS NURSING HOME CARE. IN SOME STATES THERE ARE MODIFIED ELIBILITY REQUIREMENTS FOR THIS BENEFIT. FOR EXAMPLE, IN CASES WHERE A MARRIED COUPLE OWNS A HOME AND THE WIFE NEEDS TO GO INTO A NURSING HOME, THE HUSBAND DOES NOT HAVE TO SELL THE HOME FOR HIS WIFE TO QUALIFY FOR MEDICAID. WHEN AN APPLICANT HAS ASSETS, A STATE OFFICIAL WILL GENERALLY MEET WITH FAMILY OR LEGAL REPRESENTATIVES AND AGREE ON A PLAN FOR LIQUIDATING THOSE ASSETS BY A CERTAIN DATE WITH THE PROCEEDS GOING TO THE STATE.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (**SCHIP**) — ALSO ADMINISTERED BY CMS, SCHIP IS SIMILAR TO MEDICAID EXCEPT THAT IT DIRECTLY TARGETS CHILDREN FOR COVERAGE, AND THE MAXIMUM FAMILY INCOME LEVELS ARE HIGHER THAN WITH

MEDICAID.

NON-HHS GOVERNMENT HEALTH INSURANCE PROGRAMS

VETERANS BENEFITS (ADMINISTERED BY THE DEPARTMENT OF VETERANS' AFFAIRS) - HEALTH CARE PROVIDED DIRECTLY TO QUALIFYING MILITARY VETERANS, NORMALLY AT VETERAN'S AFFAIRS FACILITIES.

WORKMAN'S COMPENSATION INSURANCE (ADMINISTERED BY THE DEPARTMENT OF LABOR) - HEALTH INSURANCE AWARDED TO WORKERS WHO HAVE BEEN INJURED ON THE JOB, FINANCED BY THE FORMER EMPLOYER UNDER GOVERNMENT SUPERVISION.

MANY RECIPIENTS OF VA AND WORKMAN'S COMPENSATION INSURANCE ARE ALSO MEDICARE BENEFICIARIES, WHICH MAY LEAD SOME CALLERS TO CONFUSE THESE PROGRAMS.

WE CAN TAKE A COMPLAINT OVER INSTANCES WHERE PROVIDERS INTENTIONALLY BILL MEDICARE FOR SERVICES THAT SHOULD HAVE BEEN COVERED BY VETERANS BENEFITS OR WORKMAN'S COMPENSATION INSURANCE.

WE DO NOT TAKE COMPLAINTS REGARDING ELIGIBILITY FOR VETERANS BENEFITS OR WORKMAN'S COMPENSATION INSURANCE.

WE DO NOT TAKE COMPLAINTS REGARDING FRAUD OR QUALITY OF CARE IN INSTANCES WHERE VETERANS BENEFITS OR WORKMAN'S COMPENSATION INSURANCE IS THE ONLY PAYOR.

HHS PUBLIC ASSISTANCE PROGRAMS

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (**TANF**) - PROVIDES DIRECT CASH ASSISTANCE TO LOW-INCOME FAMILIES.

FORMERLY KNOWN AS AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC), THIS IS THE PROGRAM THAT MOST PEOPLE HAVE IN MIND WHEN THEY SPEAK OF "WELFARE."

LIKE MEDICAID, THE TANF PROGRAM IS SUBSIDIZED AT THE FEDERAL LEVEL, BUT ADMINISTERED AT THE STATE LEVEL.

HEAD START - FUNDS PRE-SCHOOL PROGRAMS FOR LOW-INCOME CHILDREN, INCLUDING MEDICAL, NUTRITIONAL, AND EDUCATIONAL ASSISTANCE.

HEAD START GRANTS ARE AWARDED DIRECTLY TO LOCAL PUBLIC AGENCIES, PRIVATE ORGANIZATIONS, INDIAN TRIBES AND SCHOOL SYSTEMS FOR THE PURPOSE OF OPERATING HEAD START PROGRAMS AT THE COMMUNITY LEVEL.

SIMILARLY, HHS FUNDS FOSTER CARE, ENERGY ASSISTANCE, SERVICES FOR MIGRANTS, AND A MULTITUDE OF OTHER "HUMAN SERVICES."

THE ONE CONSTANT FOR HHS PUBLIC ASSISTANCE PROGRAMS IS THAT PARTICIPANTS MUST MEET AN INCOME AND ASSET THRESHOLDS (WHICH WILL ALSO VARY FROM STATE TO STATE, AND MIGHT VARY ACCORDING TO THE PROGRAM).

DIFFERENT STATES MIGHT ALSO SET OTHER REQUIREMENTS FOR PROGRAM BENEFICIARIES, SUCH AS MANDATORY DRUG MONITORING OR PARTICIPATION IN JOB TRAINING.

NON-HHS PUBLIC ASSISTANCE PROGRAMS

THERE ARE THOSE PEOPLE WHO REGARD ANY BENEFIT FROM THE GOVERNMENT AS "WELFARE" AND WHO WILL TEND TO LUMP TOGETHER ALL PUBLIC ASSISTANCE PROGRAMS.

SO TO SCREEN CALLS EFFECTIVELY, YOU SHOULD BE AWARE OF THE

MAIN ASSISTANCE PROGRAMS NOT ADMINISTERED BY HHS.

FOOD STAMPS - ASSISTANCE EARMARKED SPECIFICALLY TO PURCHASE CERTAIN KINDS OF FOOD. (ADMINISTERED BY THE DEPARTMENT OF AGRICULTURE)

HOUSING BENEFITS - HOUSING BENEFITS CAN TAKE 2 FORMS: A UNIT IN A PUBLIC HOUSING PROJECT OR A VOUCHER TOWARD HOUSING COSTS IN A PRIVATELY RUN APARTMENT. THE LATTER IS ALSO KNOWN AS **SECTION 8 BENEFITS**. (ADMINISTERED BY THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT)

SOCIAL SECURITY SUPPLEMENTAL INCOME - MONTHLY PAYMENTS MADE TO SENIOR CITIZENS WHO QUALIFY FOR SOCIAL SECURITY BENEFITS (ADMINISTERED BY THE SOCIAL SECURITY ADMINISTRATION).

SOCIAL SECURITY RECIPIENTS USUALLY BECOME ELIGIBLE FOR MEDICARE BENEFITS AT THE SAME TIME THEY BEGIN DRAWIN SOCIAL SECURITY.

SOCIAL SECURITY DISABILITY - MONTHLY PAYMENTS MADE PERSONS WHO HAVE BEEN DETERMINED TO BE LEGALLY DISABLED (ADMINISTERED BY THE SOCIAL SECURITY ADMINISTRATION).

A PERSON WHO IS CONSIDERED TO BE LEGALLY DISABLED FOR A PERIOD OF 2 YEARS BECOMES ELIGIBLE FOR MEDICARE BENEFITS, WHICH LEADS SOME TO CONFUSE THE TWO PROGRAMS.

WIC (WOMEN, INFANTS AND CHILDREN) - DIRECT FOOD ASSISTANCE. (ADMINISTERED BY THE DEPARTMENT OF AGRICULTURE)

GIVEN THE HIGH VISIBILITY OF HHS AS A PROVIDER OF “HUMAN SERVICES” MANY PEOPLE WILL ASSUME THAT WE ARE RESPONSIBLE FOR FRAUD AND ABUSE IN ALL GOVERNMENT ASSISTANCE PROGRAMS.

MANY OF THESE BENEFITS WILL BE ADMINISTERED THROUGH THE SAME SOCIAL SERVICES DEPARTMENT AT THE LOCAL LEVEL, WHICH WILL FURTHER LEAD PEOPLE TO ASSUME THAT ALL ASSISTANCE PROGRAMS ARE MANAGED BY ONE AGENCY AT THE FEDERAL LEVEL.

IN AN EFFORT TO CONTROL THE ABUSE OF BENEFITS, SOME STATES ISSUE DEBIT CARDS TO BENEFICIARIES THAT MUST BE USED TO RECEIVE SERVICES — SO A CALLER MAY MAKE REFERENCE TO "THE BLUE CARD."

SO YOU MUST LISTEN TO CALLERS VERY CAREFULLY TO MAKE SURE THAT THE PROGRAM THEY ARE DISCUSSING IS UNDER OUR JURISDICTION. DO NOT SETTLE FOR A STATEMENT THAT SOMEONE IS "GETTING A CHECK" OR "RIPPING OFF THE GOVERNMENT." FOR EXAMPLE, IF THE CALLER TALKS ABOUT SOMEONE FAKING AN INJURY, THIS SHOULD BE A CLUE TO YOU THAT THE PROGRAM BEING DEFRAUDED WOULD BE SOCIAL SECURITY DISABILITY OR WORKMAN'S COMPENSATION.

SCREENING PUBLIC ASSISTANCE COMPLAINTS

COMPLAINTS INVOLVING PUBLIC ASSISTANCE PROGRAMS WILL GENERALLY FALL INTO TWO CATEGORIES: ALLEGATIONS THAT A BENEFICIARY DOES NOT MEET THE ELIGIBILITY REQUIREMENTS FOR PROGRAM PARTICIPATION AND ALLEGATIONS REGARDING FRAUD BY THOSE ADMINISTERING THE PROGRAM.

BENEFICIARY ELIGIBILITY FRAUD

MANY OF THOSE REPORTING VIOLATIONS IN PUBLIC ASSISTANCE PROGRAMS ARE MOTIVATED BY SPITE RATHER THAN CIVIC RESPONSIBILITY — SO DO NOT BE SURPRISED IF THE CONVERSATIONS VEER INTO NASTY PERSONAL DISPUTES INVOLVING PARENTS, NEIGHBORS, OR FORMER SPOUSES.

TYPES OF COMPLAINTS

MANY OF THE CALLS THAT COME TO THE HOTLINE WITH REGARD TO PUBLIC ASSISTANCE PROGRAMS WILL CHALLENGE THE PROGRAM RECIPIENT'S ELIGIBILITY TO RECEIVE BENEFITS. THIS MIGHT INVOLVE –

- A BENEFICIARY WHO HAS CONCEALED INCOME OR ASSETS IN ORDER TO QUALIFY FOR ASSISTANCE
- A BENEFICIARY RECEIVING BENEFITS FOR CHILDREN WHO ARE NOT IN THAT PERSON'S CARE
- A BENEFICIARY RECEIVING ASSISTANCE UNDER MULTIPLE NAMES AND/OR IN MULTIPLE JURISDICTIONS;
- A FAMILY HIDING ASSETS IN ORDER TO QUALIFY AN ELDERLY RELATIVE FOR MEDICAID (NURSING HOME CARE).

FOR ALL INSTANCES WHERE THE RECIPIENT'S ELIGIBILITY STATUS IS THE CORE OF THE COMPLAINT, YOU SHOULD STRONGLY URGE THE CALLER TO CALL THE STATE AGENCY THAT QUALIFIED THE RECIPIENT. YOU CAN INFORM THE CALLER THAT ALTHOUGH OUR DEPARTMENT FUNDS THE AID, OIG RARELY TAKES DIRECT INVOLVEMENT INVESTIGATING ELIGIBILITY FRAUD; OUR NORMAL COURSE OF ACTION IS TO REFER THE COMPLAINT TO THE APPROPRIATE STATE AGENCY.

IF THE CALLER SIMPLY INSISTS ON LODGING THE COMPLAINT WITH US, THEN TAKE THE COMPLAINT.

WHEN SCREENING A CALL INVOLVING **MEDICAID** IT IS ESSENTIAL THAT YOU IDENTIFY THE NATURE OF THE COMPLAINT.

- COMPLAINTS INVOLVING A MEDICAID **RECIPIENT'S**

ELIGIBILITY SHOULD FOLLOW THE GENERAL INSTRUCTIONS FOR RECIPIENT ELIGIBILITY: REFER THE CALLER TO THE STATE MEDICAID OFFICE.

- COMPLAINTS INVOLVING FRAUD OR MISCONDUCT ON THE PART OF HEALTH CARE **PROVIDER** THAT BILLS MEDICAID FOR SERVICES SHOULD BE SCREENED USING THE SAME INSTRUCTIONS FOR SCREENING MEDICARE COMPLAINTS.

KEEP IN MIND THAT THERE ARE CERTAIN CATEGORIES OF PROVIDERS WHICH BILL MEDICAID BUT MIGHT NOT BILL MEDICARE, SUCH AS PEDIATRICIANS, DENTISTS, PARATRANSIT CARRIERS, AND OBSTETRICIANS

COMPLAINT INFORMATION

IN ADDITION TO THE CALLER'S PERSONAL INFORMATION, YOU WILL NEED RECIPIENT'S FULL NAME, ADDRESS AND PHONE NUMBER. IT IS ESSENTIAL TO IDENTIFY PRECISELY WHAT ASSISTANCE PROGRAMS THE RECIPIENT IS ENROLLED IN. THE COMPLAINT NARRATIVE SHOULD EXPLAIN PRECISELY HOW THE RECIPIENT HAS VIOLATED THE GUIDELINES FOR PROGRAM PARTICIPATION, AND THE TIME FRAME INVOLVED. IT WOULD BE HELPFUL IF THE CALLER KNOWS THE RECIPIENT'S SOCIAL SECURITY NUMBER, ALONG WITH ANY IDENTIFICATION NUMBER RELATED TO THE PROGRAMS IN QUESTION.

GRIEVANCES / APPEALS

YOU WILL RECEIVE CALLS FROM INDIVIDUALS WHO ARE ESSENTIALLY APPEALING A DECISION BY A STATE SOCIAL SERVICES AGENCY; THIS MIGHT BE SOMEONE WHO WAS TURNED DOWN FOR BENEFITS, IS FACING A CUT-OFF OF BENEFITS, OR HAS A PROBLEM WITH HIS STATE-APPOINTED CASE-WORKER.

SUCH CALLERS WILL ARGUE THAT BECAUSE THE STATE AGENCY RECEIVES FUNDING FROM THE DEPARTMENT, THEN THE HOTLINE IS

THE PROPER VENUE FOR ANY COMPLAINTS REGARDING THE AGENCY. SIMILARLY, OTHERS MIGHT ARGUE THAT THEIR PARTICULAR PROBLEMS ARE INDICATIVE OF BROADER PATTERNS OF "MISMANAGEMENT."

AS AN EXAMPLE, THE HOTLINE HAS RECEIVED NUMEROUS CALLS FROM PARENTS WHO HAVE HAD THEIR PARENTAL RIGHTS TERMINATED, RESULTING IN THEIR CHILDREN BEING PLACED IN FOSTER CARE. THESE CALLERS WILL ALLEGE THAT THE INVESTIGATION THAT LED TO THIS OUTCOME WAS FLAWED: STATE OFFICIALS LIED OR IGNORED IMPORTANT EVIDENCE, THEIR ATTORNEY DID NOT REPRESENT THEM WELL, AND/OR THE JUDGE WAS BIASED. THEY WILL ARGUE THAT BECAUSE HHS SUBSIDIZES FOSTER CARE, OIG NEEDS TO INVESTIGATE THEIR CASE FOR POTENTIAL FRAUD. MOREOVER, MANY WILL CLAIM THAT THEY KNOW OF MANY SIMILAR CASES TO TRY TO CONVINCE YOU THAT IT IS A SYSTEMIC PROBLEM.

GIVEN THIS HYPOTHETICAL SITUATION IT IS NOT TOO DIFFICULT TO DISCERN THAT THE CALLER'S REAL MOTIVE IS TO PROTEST THE DECISION TO TERMINATE HIS PARENTAL RIGHTS AND TO SET THE WHEELS IN MOTION OF REGAINING CUSTODY.

YOU WILL NEED TO EXPLAIN TO SUCH A CALLER THAT APPEALS OF BENEFITS DECISIONS AND OTHER ADMINISTRATIVE ACTIONS SHOULD BE PURSUED THROUGH REGULAR CHANNELS, AND GRIEVANCES AGAINST STATE EMPLOYEES SHOULD BE DIRECTED TO THE STATE AGENCIES THEMSELVES.

BE FOREWARNED THAT SUCH CALLERS WILL NOT EASILY ACCEPT THE IDEA THAT WE CANNOT HELP THEM.

STATE AGENCIES

THE STATE AGENCIES THAT ADMINISTER ASSISTANCE PROGRAMS FUNDED BY THE DEPARTMENT ARE ALSO POTENTIAL TARGETS OF COMPLAINTS.

IN GENERAL, STATE AGENCIES ACCEPT CERTAIN CONDITIONS REGARDING ACCOUNTING AND PROGRAM REQUIREMENTS IN ORDER TO RECEIVE DEPARTMENT FUNDING, WHICH AUTOMATICALLY SUBJECTS THEM TO DEPARTMENT SCRUTINY. THE DEPARTMENT, AND OIG, PERIODICALLY AUDIT STATE AGENCIES' PERFORMANCE.

THERE ARE A VARIETY OF WAYS A STATE AGENCY COULD DEFRAUD THE DEPARTMENT:

- AN AGENCY COULD MANIPULATE STATISTICS TO EXAGGERATE THE NUMBER OF BENEFICIARIES, THUS INFLATING THE HHS PAYMENT TO THE STATE

- AN AGENCY MIGHT DEFLECT FUNDS FOR USES OTHER THAN THOSE INTENDED.

BUT IT WOULD NORMALLY REQUIRE AN EMPLOYEE OR SOME OTHER INSIDER TO BE AWARE OF SUCH A PROBLEM.

TO SCREEN OUT GRIEVANCES MASKED AS FRAUD COMPLAINTS, YOU SHOULD NOT TAKE A COMPLAINT UNLESS THE CALLER CAN IDENTIFY THE HHS OPERATING DIVISION OR PROGRAM THAT IS THE SOURCE OF THE FUNDS INVOLVED; DO NOT SETTLE FOR "THEY GET MONEY FROM YOU GUYS." YOU MAY NEED TO EXPLAIN TO THE CALLER THAT PART OF OUR JOB IS TO MAKE SURE THE ISSUE AT HAND FALLS UNDER OIG JURISDICTION.

COMPLAINT INFORMATION

IN ADDITION TO THE CALLER'S PERSONAL INFORMATION, YOU SHOULD COLLECT THE CORRECT NAME OF THE STATE AGENCY INVOLVED AND OF THE HHS PROGRAM. IF THE SITUATION RELATES AS PARTICULAR OFFICE OF THE STATE AGENCY INVOLVED, THIS SHOULD BE MADE CLEAR. IF THE CALLER CAN IDENTIFY PARTICULAR EMPLOYEES OF THE STATE AGENCY WHO ARE INVOLVED, THEY SHOULD BE NAMED. THE COMPLAINT NARRATIVE SHOULD EXPLAIN

PRECISELY HOW THE STATE AGENCY IS DEFRAUDING THE DEPARTMENT OR MISSPENDING DEPARTMENT FUNDS.

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SAMPLE COMMENTS

BENEFICIARY ELIGIBILITY COMPLAINTS

1. THE ANONYMOUS CALLER ALLEGES THAT MARY MASON HAS BEEN RECEIVING TANF BENEFITS FOR 2 YEARS BUT HAS NOT REPORTED THE INCOME SHE RECEIVES WORKING AT THE FOP LODGE (111 SUMMERS DRIVE, WASHINGTON, DC (202)555-5555). MS. MASON TOLD THE CALLER THAT SHE EARNS $250-300 PER WEEK AT THIS JOB. MS. MASON'S AFDC CASE NUMBER IS 011223344 AND HER SOCIAL SECURITY NUMBER IS 987-65-4321.

2. MR. JONES ALLEGES THAT JENNY JONES, HIS EX-WIFE, HAS ENROLLED THEIR CHILD, JOHN JONES, ON MEDICAID, EVEN THOUGH SHE DOES NOT HAVE CUSTODY OF THE CHILD. JOHN JONES IS ALREADY INSURED BY COVERAGE PURCHASED BY MR. JONES. MR. JONES SUSPECTS HIS EX-WIFE DID THIS TO BECOME ELIGIBLE FOR MEDICAID HERSELF. HIS SON'S MEDICAID ID IS 5544332211.

MEDICAID PROVIDER FRAUD

1. THE ANONYMOUS CALLER CLAIMED TO BE AN EMPLOYEE OF THE PRINCE GEORGES COUNTY (MD) SCHOOL BOARD. THE CALLER ALLEGED THAT THERE IS A SYSTEMATIC POLICY OF HAVING STUDENTS ON MEDICAID DIAGNOSED AS REQUIRING SPEECH THERAPY. THE THERAPY IS THEN PROVIDED BY SCHOOL BOARD EMPLOYEES AND BILLED TO MEDICAID. THE CALLER STATED THAT SHE DOES NOT KNOW IF ANY OF THE STUDENTS ACTUALLY REQUIRE THE THERAPY BUT IT CAUGHT HER ATTENTION THAT ALMOST ALL OF THE STUDENTS RECEIVING THERAPY ARE ON MEDICAID.

2. MS. COLLINS IDENTIFIED HERSELF AS A DENTAL ASSISTANT WHO WORKS AT WE LOVE KIDS DENTAL CENTER. SHE EXPLAINED THAT THEY RECEIVE MANY REFERRALS FROM LAKESIDE CENTER, A RESIDENTIAL FACILITY FOR TROUBLED YOUTH. MOST OF THE CHILDREN FROM THE FACILITY ARE ON MEDICAID. MS. COLLINS ALLEGED THAT THESE CHILDREN ARE ROUTINELY ADMINISTERED UNNECESSARY SERVICES; SOME CHILDREN RECEIVE TEN CROWNS. MS. COLLINS STATED THAT DR. JOHN JAMES, THE OWNER, MAKES IT A POINT TO SEE THESE CHILDREN PERSONALLY. THE CHILDREN ARE ACCOMPANIED BY A DRIVER WHO DOES NOT QUESTION THE SERVICES.

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CHILD SUPPORT ENFORCEMENT

AS A RULE THE ADMINISTRATION AND ENFORCEMENT OF CHILD SUPPORT PAYMENTS FALL UNDER THE JURISDICTION OF STATE AGENCIES, THE FEDERAL GOVERNMENT ACQUIRED AUTHORITY TO PURSUE INDIVIDUALS WHO CROSS STATE LINES TO AVOID CHILD SUPPORT PAYMENTS.

BECAUSE THE NON-PAYMENT OF CHILD SUPPORT OFTEN FORCES CUSTODIAL PARENTS AND THEIR CHILDREN ON TO DHHS PUBLIC ASSISTANCE PROGRAMS, THE DEPARTMENT HAS BEEN ASSIGNED THE LEAD ROLE IN THESE CASES.

THESE EFFORTS ARE COORDINATED BY THE OFFICE OF CHILD SUPPORT ENFORCEMENT (OCSE).

SCREENING

WE TAKE COMPLAINTS INVOLVING NON-PAYMENT OF CHILD SUPPORT IF THE FOLLOWING CRITERIA ARE MET:

- THE NON-PAYING PARENT RESIDES IN A DIFFERENT STATE THAN WHERE THE PAYMENT ORDER WAS ISSUED
- THE AMOUNT OF ARREARAGE EXCEEDS $5,000, OR, THE TERM OF NON-PAYMENT IS OVER A YEAR.

IF BOTH PARTIES ARE LIVING IN THE STATE WHERE THE PAYMENT ORDER WAS ISSUED, THERE IS NO JURISDICTION AT THE FEDERAL LEVEL. A CALLER WITH THESE CIRCUMSTANCES SHOULD BE REFERRED TO HER LOCAL CHILD SUPPORT ENFORCEMENT OFFICE OR TO THE COURT THAT ISSUED THE ORDER.

COMPLAINT INFORMATION

FOR COMPLAINTS INVOLVING CHILD SUPPORT ENFORCEMENT, IN ADDITION TO SOLICITING AN ADDRESS AND PHONE NUMBER INFORMATION FOR THE CALLER AND FOR THE NON-PAYING PARENT, YOU SHOULD TRY TO RECORD —

- THE NON-PAYING PARENT'S SOCIAL SECURITY NUMBER;
- THE NON-PAYING PARENT'S PLACE OF WORK;
- THE LOCATION OF THE COURT THAT ISSUED THE SUPPORT OBLIGATION, ALONG WITH THE CASE NUMBER;
- THE AMOUNT OWED AND TERM OF NON-PAYMENT;
- THE NAMES OF THE CHILDREN AFFECTED.

APPEALS

THE OIG HOTLINE IS NOT THE PROPER VENUE TO CHALLENGE THE TERMS OF A CHILD SUPPORT ORDER OR THE PROCESS BY THE ORDER WAS ISSUED.

A CALLER WISHING TO INCREASE PAYMENTS, DECREASE PAYMENTS, OR IN ANY WAY AMEND A CHILD SUPPORT ORDER – AND THIS PERTAINS TO NON-CUSTODIAL PARENTS ALSO – WILL NEED TO SEEK REMEDY BEFORE THE COURT THAT ISSUED THE ORDER.

SAMPLE COMMENT

MS. SMITH ALLEGES THAT HER FORMER HUSBAND, JOHN SMITH, HAS MOVED FROM VIRGINIA TO WEST VIRGINIA TO AVOID MAKING CHILD SUPPORT PAYMENTS FOR THEIR DAUGHTER, SALLY SMITH (456-78-9123). MR. SMITH WAS ORDERED TO PAY $500.00 PER MONTH BY HARRISON COUNTY DISTRICT COURT ORDER 23-456-7 IN JUNE 2004.

HE NEVER MADE A PAYMENT, AND IS NOW APPROXIMATELY $12,000 IN ARREARS. MS. SMITH STATES HER MR. SMITH WORKS AT SUMMERS LUMBER IN FAIRMOUNT, WV. SHE DID NOT KNOW MR. SMITH'S SOCIAL SECURITY NUMBER.

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U.S. Department of Health & Human Services
Office of Inspector General

THE OIG HOTLINE - MISSION ORIENTATION

JULY 2010

FOR OFFICIAL USE ONLY
This information is intended for the internal use of the OIG Hotline staff only.

PREFACE

WELCOME TO THE HOTLINE OF THE INSPECTOR GENERAL FOR THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

AS A REPRESENTATIVE OF THE HOTLINE, YOU WILL BE ASSISTING CITIZENS WHO CALL THE HOTLINE'S TOLL-FREE NUMBER OR WRITE TO THE HOTLINE TO REPORT FRAUD, WASTE, AND ABUSE IN THE PROGRAMS OF THE DEPARTMENT. THE COMPLEX NATURE OF SCREENING THESE COMPLAINTS WILL CHALLENGE YOU TO DEVELOP BOTH YOUR ANALYTICAL AND COMMUNICATIONS SKILLS.

YOU WILL BE PROVIDING CUSTOMER SERVICE TO THE PUBLIC AT LARGE AS WELL AS COLLECTING INFORMATION THAT COULD POTENTIALLY LEAD TO CRIMINAL PROSECTUTION AND THE RECOVERY OF FRAUDLENTLY ACQUIRED FUNDS. THESE DUAL ROLES CAN RESULT IN UNIQUE CHALLENGES. FOR EXAMPLE, UNLIKE MOST CUSTOMER SERVICE POSITIONS, WHERE YOUR GOAL IS TO PERSUADE RELUCTANT CUSTOMERS TO RELY ON YOUR COMPANY FOR A PARTICULAR SERVICE, AS A HOTLINE REPRESENTATIVE YOU WILL OFTEN BE CALLED UPON TO CONVINCE EAGER CALLERS THAT THEIR CONCERNS WOULD BE BETTER HANDLED BY A DIFFERENT AGENCY.

TO HELP PREPARE YOU TO HANDLE THESE CHALLENGES THIS DOCUMENT IS INTENDED TO PROVIDE ORIENTATION TO THE SCOPE OF DEPARTMENT PROGRAMS (PARTICULARLY MEDICARE), THE ROLE OF THE INSPECTOR GENERAL, AND THE HOTLINE'S CONTRIBUTON TO THE WORK OF THE INSPECTOR GENERAL.

THROUGHOUT THE DOCUMENT THERE ARE LINKS TO RELEVANT WEBSITES EMBEDDED THAT PROVIDE EITHER ADDITIONAL PROGRAM DETAILS OR CONTACT INFORMATION THAT YOU MAY NEED TO FURNISH TO CALLERS.

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THE OFFICE OF INSPECTOR GENERAL

THE OFFICE OF INSPECTOR GENERAL (OIG) WAS CREATED BY ACT OF CONGRESS IN 1978 TO CREATE "INDEPENDENT AND OBJECTIVE" UNITS WITHIN FEDERAL AGENCIES FOR THE PURPOSE OF DETECTING AND PREVENTING FRAUD AND ABUSE. ALL MAJOR FEDERAL AGENCIES AND PROGRAMS HAVE AN INSPECTOR GENERAL (SEE LIST).

THE INSPECTOR GENERAL FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) CONDUCTS AUDITS, INSPECTIONS, AND CRIMINAL INVESTIGATIONS TO PROTECT THE INTEGRITY OF HHS PROGRAMS.

WITH AN ANNUAL BUDGET TOTALING HUNDREDS OF BILLIONS OF DOLLARS, HHS IS THE LARGEST GRANT-MAKING AGENCY IN THE FEDERAL GOVERNMENT AND THE NATION'S LARGEST HEALTH INSURER, THUS PRESENTS A HIGH POTENTIAL FOR FRAUD AND ERRANT SPENDING.

INFORMATION COLLECTED BY THE OIG CAN BE USED TO ALERT HHS MANAGEMENT AND CONGRESS TO POTENTIAL PROBLEMS OR TO PROVIDE EVIDENCE IN CRIMINAL PROSECUTIONS.

THE OIG MIGHT SUGGEST PROPOSE PROGRAM IMPROVEMENTS TO CORRECT ONGOING PROBLEMS IT UNCOVERS, BUT THE OIG IS NOT A POLICY-MAKING OFFICE.

ORGANIZATIONALLY OIG IS DIVIDED INTO FIVE COMPONENTS: OFFICE OF AUDIT SERVICES, OFFICE OF COUNSEL TO THE INSPECTOR GENERAL, OFFICE OF EVALUATION AND INSPECTIONS, OFFICE OF INVESTIGATION, OFFICE OF MANAGEMENT AND POLICY.

OFFICE OF AUDIT SERVICES (OAS)

OAS PROVIDES ALL AUDITING SERVICES FOR HHS, EITHER BY CONDUCTING AUDITS WITH ITS OWN AUDIT RESOURCES OR BY OVERSEEING AUDIT WORK DONE BY OTHERS. AUDITS EXAMINE THE PERFORMANCE OF HHS PROGRAMS AND/OR ITS GRANTEES AND CONTRACTORS IN CARRYING OUT THEIR RESPECTIVE RESPONSIBILITIES, AND ARE INTENDED TO PROVIDE INDEPENDENT ASSESSMENTS OF HHS PROGRAMS AND OPERATIONS IN ORDER TO REDUCE WASTE, ABUSE AND MISMANAGEMENT AND TO PROMOTE ECONOMY AND EFFICIENCY THROUGHOUT THE DEPARTMENT.

OFFICE OF COUNSEL TO THE INSPECTOR GENERAL (OCIG)

OCIG PROMOTES THE OVERALL MISSION OF THE OFFICE OF INSPECTOR GENERAL THROUGH TIMELY, ACCURATE AND PERSUASIVE LEGAL ADVOCACY AND COUNSEL.

OCIG IMPOSES AND LITIGATES CIVIL MONETARY PENALTIES (CMP'S) AND EXCLUSIONS AGAINST PROVIDERS UNDER THE MEDICARE AND MEDICAID PROGRAMS. OCIG FORMULATES OIG REGULATIONS ON ITS SANCTIONS AUTHORITIES AND ADVISES OIG AND THE PUBLIC ON THE EXERCISE OF THOSE AUTHORITIES. OCIG REPRESENTS OIG IN THE SETTLEMENT OF FEDERAL COURT CASES ARISING UNDER THE CIVIL FALSE CLAIMS ACT, AND DETERMINES WHETHER OIG WILL WAIVE ITS EXCLUSION AND CMP AUTHORITIES IN SUCH CASES. OCIG DEVELOPS AND MONITORS CORPORATE INTEGRITY AGREEMENTS AND DEVELOPS MODEL COMPLIANCE PLANS. OCIG RENDERS ADVISORY OPINIONS TO THE HEALTH CARE INDUSTRY AND MEMBERS OF THE PUBLIC ON WHETHER AN ACTIVITY OR PROPOSED TRANSACTION WOULD CONSTITUTE GROUNDS FOR THE IMPOSITION OF A SANCTION UNDER THE ANTI-KICKBACK STATUTE, THE CMP LAW OR PROGRAM EXCLUSION AUTHORITIES, AND ISSUES FRAUD ALERTS AND OTHER INDUSTRY GUIDANCE ON THESE SANCTION AUTHORITIES.

OCIG ALSO PROVIDES GENERAL LEGAL SERVICES TO OIG, RENDERING ADVICE AND OPINIONS ON HHS PROGRAMS AND OPERATIONS AND THE SCOPE AND EXERCISE OF THE INSPECTOR GENERAL'S AUTHORITIES AND RESPONSIBILITIES. OCIG PROVIDES ALL LEGAL SUPPORT IN THE INTERNAL OPERATIONS OF OIG, INCLUDING INVESTIGATIVE TECHNIQUES AND PROCEDURES (INCLUDING CRIMINAL PROCEDURE), APPROPRIATIONS, THE SUFFICIENCY AND IMPACT OF LEGISLATIVE PROPOSALS AFFECTING OIG, DELEGATIONS OF AUTHORITY, ETHICS, PERSONNEL MATTERS, THE DISCLOSURE OF INFORMATION UNDER THE FREEDOM OF INFORMATION ACT, AND THE SAFEGUARDING OF INFORMATION UNDER THE PRIVACY ACT. OCIG IS PRIMARILY RESPONSIBLE FOR DEFENDING OIG IN ALL LITIGATION INVOLVING THE VARIOUS OIG COMPONENTS.

OFFICE OF EVALUATIONS AND INSPECTIONS (OEI)

OEI WAS CREATED IN 1985 TO GIVE THE OIG GREATER FLEXIBILITY AND BROADER OVERSIGHT OF THE DEPARTMENT'S PROGRAMS. THE OEI'S MISSION IS TO IMPROVE HHS PROGRAMS BY CONDUCTING EVALUATIONS THAT PROVIDE TIMELY, USEFUL, AND RELIABLE INFORMATION AND ADVICE TO DECISION MAKERS.

OEI CONDUCTS SHORT-TERM MANAGEMENT AND PROGRAM EVALUATIONS (CALLED INSPECTIONS) THAT FOCUS ON ISSUES OF CONCERN TO THE SECRETARY OF HHS, DEPARTMENT PROGRAM MANAGERS, CONGRESS, AND THE PUBLIC. THESE EVALUATIONS EXAMINE PROGRAMS FROM A BROADER, MORE ISSUE- ORIENTED PERSPECTIVE THAN THE TRADITIONAL AUDITS OR CRIMINAL INVESTIGATIONS ALSO CONDUCTED BY THE OIG.

OFFICE OF INVESTIGATIONS (OI)

OI WITHIN THE OFFICE OF INSPECTOR GENERAL IS THE PRINCIPAL INVESTIGATIVE ARM OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. THE BACKBONE OF OI IS A STAFF OF PROFESSIONAL

CRIMINAL INVESTIGATORS OR SPECIAL AGENTS. THE PRIMARY RESPONSIBILITY OF OI SPECIAL AGENTS IS TO DETECT AND PREVENT WASTE, FRAUD, AND ABUSE WITHIN THE NUMEROUS DEPARTMENTAL PROGRAMS. IN AN EFFORT TO FULFILL THEIR MISSION, SPECIAL AGENTS CONDUCT VARIOUS CRIMINAL, CIVIL, AND ADMINISTRATIVE INVESTIGATIONS.

OI IS ALSO RESPONSIBLE FOR MANAGING THE OFFICE OF INSPECTOR GENERAL'S HOTLINE, AND WILL USE DATA GENERATED FROM THE HOTLINE TO ANALYZE TRENDS TO PREVENT FRAUD AND ABUSE.

OI SPECIAL AGENTS ALSO ENSURE THE SAFETY AND PROTECTION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

OFFICE OF MANAGEMENT AND POLICY (OMP)

OMP PROVIDES MISSION AND ADMINISTRATIVE SUPPORT SERVICES TO THE OIG BY MANAGING BUDGET FORMULATION AND EXECUTION; POLICY DEVELOPMENT; PERSONNEL SECURITY; DISSEMINATION OF OIG INFORMATION; INFORMATION TECHNOLOGY; HUMAN RESOURCES; EXECUTIVE RESOURCES; AND OIG FACILITIES. OMP ALSO ENSURES PERFORMANCE QUALITY AND EXECUTION COMPLIANCE WITH CURRENT AND EMERGING GOVERNMENT REGULATIONS, DIRECTIVES, AND MANDATES.

THE INSPECTOR GENERAL'S HOTLINE

THE MISSION OF THE HOTLINE IS TO RECEIVE TIPS FROM THE GENERAL PUBLIC CONCERNING POSSIBLE FRAUD IN PROGRAMS AND INITIATIVES UNDER THE JURISDICTION OF HHS.

THE HOTLINE DOES NOT INITIATE INVESTIGATIONS OR OPEN "CASES."

THE HOTLINE REFERS EACH TIP IT RECEIVES TO AN APPROPRIATE AGENCY FOR EVALUATION AND DEVELOPMENT.

ALTHOUGH ORGANIZATIONALLY LOCATED WITHIN THE OFFICE OF INVESTIGATIONS, THE HOTLINE WORKS COOPERATIVELY WITH ALL OIG COMPONENTS.

THE HOTLINE MAINTAINS A DATA BASE OF ALLEGATIONS PROCESSED.

THE ROLE OF THE HOTLINE AGENT

AS A HOTLINE CONTRACTOR EMPLOYEE, YOU WILL BE REPRESENTING THE OIG, HHS, AND THE U.S. GOVERNMENT BEFORE THE PUBLIC.

YOU WILL SCREEN CALLS FOR THE PURPOSE OF DETERMINING WHETHER THE COMPLAINANTS HAVE INFORMATION THAT MERITS FURTHER REVIEW AS A POSSIBLE INSTANCE OF FRAUD.

FOR THOSE CALLS THAT QUALIFY, YOU WILL ELICIT AND RECORD SUFFICIENT DETAILS FOR THE APPROPRIATE AGENCY TO REVIEW THE ALLEGATION. THE STANDARDS FOR SCREENING COMPLAINTS ARE SPELLED OUT IN A COMPANION DOCUMENT, "OIG HOTLINE SCREENING PROTOCOLS."

TO INSURE THAT THE REVIEWING OFFICIALS RECEIVE ACCURATE AND PERTINENT INFORMATION, YOU WILL NEED TO MAINTAIN A HIGH LEVEL OF CONCENTRATION WHEN ENTERING REPORT DATA.

A LARGE PERCENTAGE OF YOUR CALLS WILL INVOLVE THE MEDICARE PROGRAM, WHICH MEANS THAT MANY OF YOUR CALLERS WILL BE SENIOR CITIZENS WHO MAY BE HEARING IMPAIRED OR HAVE OTHER COGNITIVE DIFFICULTIES.

ALSO, SOME CALLS WILL COME FROM PEOPLE WHO ARE GREATLY AGITATED ABOUT AN ISSUE THAT DOES NOT FALL WITHIN THE OIG'S JURISDICTION.

KEEPING IN MIND YOUR PRIMARY FUNCTION OF COMBATING FRAUD, WASTE, AND ABUSE, YOU SHOULD STRIVE TO EXHIBIT COURTESY, RESPECT, PATIENCE, AS WELL AS SOUND JUDGEMENT AT ALL TIMES.

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WHAT IS FRAUD?

UNLIKE MOST CRIMES, THE NATURE OF "FRAUD" IS NOT SELF-EVIDENT.

THE GENERAL PUBLIC'S DEFINITION OF FRAUD IS FARREACHING TO INCLUDE ALMOST ANY ACTION THAT SOMEHOW DOES NOT SEEM RIGHT.

BUT WHEN OIG INVESTIGATES FRAUD THE TERM REFERS TO AN ACT THAT CAN BE PROSECUTED IN COURT UNDER EXISTING CRIMINAL AND CIVIL STATUTES. MOST INSTANCES WILL INVOLVE A PATTERN OF DECEPTION WITH THE FOLLOWING CHARACTERISTICS:

1) SOME STATUTE OR REGULATION MUST HAVE BEEN VIOLATED

2) THE DECEPTION MUST HAVE RESULTED IN SOME MATERIAL GAIN

3) THE DECEPTION MUST HAVE BEEN COMMITTED WITH INTENT (THE ABILITY TO PROVE THIS LATTER POINT OFTEN DICTATES WHETHER AN INFRACTION IS PURSUED AS A CRIMINAL OR CIVIL MATTER).

THIS GAP BETWEEN THE LEGAL DEFINITION OF FRAUD AND THE PUBLIC UNDERSTANDING OF FRAUD MAY CAUSE CHALLENGES: YOU ARE GOING TO HAVE TO EXPLAIN TO SOME CALLERS THAT THEIR GRIEVANCES, NO MATTER HOW LEGITIMATE OR HEARTFELT, DO NOT INVOLVE A FRAUD ISSUE THAT OIG WOULD NORMALLY INVESTIGATE.

OBVIOUSLY, NOBODY EXPECTS YOU TO PLAY JUDGE AND JURY.

AS A HOTLINE AGENT YOU WILL TRY TO SCREEN INCOMING CALLS ACCORDING TO THESE THREE BASIC QUESTIONS:

1) DOES THE CALL INVOLVE A PROGRAM OR INITIATIVE OF THE DEPARTMENT?

2) DOES THE CALLER WANT TO MAKE AN ALLEGATION OF FRAUD? (AS OPPOSED TO HAVING A QUESTION OR POLICY COMPLAINT)?

3) DOES THE CALLER HAVE ENOUGH SPECIFIC INFORMATION TO WARRANT FURTHER REVIEW?

THE SCREENING PROTOCOLS WILL FOCUS ON HOW TO DETERMINE WHAT CIRCUMSTANCES SUGGEST THAT FURTHER REVIEW MAY BE WARRANTED.

YOU SHOULD AVOID GETTING TRAPPED INTO A DISCUSSION ABOUT THE DEFINITION OF FRAUD: THIS IS A NO-WIN SITUATION.

SIMILARLY, YOU SHOULD AVOID MAKING ANY KIND OF CATEGORICAL STATEMENT AS TO WHETHER A SET OF CIRCUMSTANCES CONSTITUTES FRAUD.

WHEN IT IS NECESSARY TO EXPLAIN TO A CALLER WHY YOU ARE NOT TAKING AN ALLEGATION, YOU SHOULD REFER TO THE GUIDELINES PROVIDED IN THE SCREENING PROTOCOLS.

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HHS AGENCIES

BROADLY PUT, THE MISSION OF THE DEPARTMENT OF THE HEALTH AND HUMAN SERVICES (HHS) IS TO PROTECT THE HEALTH AND WELFARE OF THE POPULATION. AMONG CABINET AGENCIES, ONLY THE DEPARTMENT OF DEFENSE RECEIVES A LARGER BUDGET ALLOCATION.

THE DEPARTMENT CARRIES OUT ITS MISSION IN A VARIETY OF WAYS:

- SOME HHS EMPLOYEES, SUCH AS THE MEMBERS OF THE COMMISSIONED CORPS OF THE PUBLIC HEALTH SERVICE, DELIVER HEALTHCARE SERVICES DIRECTLY TO THE PUBLIC;
- HHS IS THE NATION'S LARGEST HEALTH INSURER, PROVIDING INSURANCE FOR THE ELDERLY AND DISABLED (MEDICARE), INDIGENT (MEDICAID) AND UNINSURED CHILDREN (CHILDREN'S HEALTH INSURANCE PROGRAM);
- HHS IS THE NATION'S LARGEST SPONSOR OF PRIMARY MEDICAL RESEARCH;
- THROUGH STATISTICAL ANALYSIS HHS MONITORS LONG TERM HEALTH AND WELFARE TRENDS IN ORDER TO IDENTIFY PRESSING PUBLIC HEALTH NEEDS;
- HHS AGENCIES ASSURE THE SAFETY OF FOOD, MEDICATIONS, AND HEALTH CARE PRODUCTS;
- HHS FUNDS PROGRAMS AIMED AT FILLING GAPS IN THE PUBLIC HEALTH CARE SYSTEM (E.G., PROVIDING INCENTIVES FOR PHYSICIANS TO LOCATE IN UNDER-SERVED REGIONS OF THE

COUNTRY) AND DEVELOPING INNOVATIVE METHODS FOR DELIVERING HEALTHCARE.

- HHS PROVIDES CASH ASSISTANCE TO LOW-INCOME FAMILIES THROUGH THE TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) PROGRAM (COMMONLY KNOWN AS "WELFARE");

- HHS SPEARHEADS EFFORTS AT THE FEDERAL LEVEL TO LOCATE AND RECOVER PAYMENT FROM NON-CUSTODIAL PARENTS WHO OWE BACK CHILD SUPPORT.

HHS WORKS IN CLOSE COOPERATION WITH STATES, LOCAL GOVERNMENTS, AND PRIVATE ORGANIZATIONS IN PURSUING ITS MISSION.

HHS OPERATING DIVISIONS

THE DEPARTMENT INCLUDES MORE THAN 300 PROGRAMS, COVERING A WIDE SPECTRUM OF ACTIVITIES (CLICK HERE FOR AN INDEX). YOU SHOULD FAMILIARIZE YOURSELF WITH THE NAMES (AND ACRONYMS) OF ALL THE DEPARTMENT'S OPERATIONAL DIVISIONS.

OFFICE OF THE SECRETARY
HUBERT H. HUMPHREY BUILDING
200 INDEPENDENCE AVENUE SW
WASHINGTON, D.C., 20201

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

NATIONAL INSTITUTES OF HEALTH

HEADQUARTERS: BETHESDA, MD

THE NIH MISSION IS TO DISCOVER NEW KNOWLEDGE THAT WILL LEAD TO BETTER HEALTH FOR EVERYONE. NIH WORKS TOWARD THAT

MISSION BY CONDUCTING RESEARCH IN ITS OWN LABORATORIES; SUPPORTING THE RESEARCH OF NON-FEDERAL SCIENTISTS IN UNIVERSITIES, MEDICAL SCHOOLS, HOSPITALS, AND RESEARCH INSTITUTIONS THROUGHOUT THE COUNTRY AND ABROAD; HELPING IN THE TRAINING OF RESEARCH INVESTIGATORS; AND FOSTERING COMMUNICATION OF MEDICAL INFORMATION.

NIH IS COMPOSED OF 27 DIFFERENT INSTITUTES, CENTERS AND OFFICES.

FOOD AND DRUG ADMINISTRATION

HEADQUARTERS: ROCKVILLE, MD

THE FDA IS RESPONSIBLE FOR PROTECTING THE PUBLIC HEALTH BY ASSURING THE SAFETY, EFFICACY, AND SECURITY OF HUMAN AND VETERINARY DRUGS, BIOLOGICAL PRODUCTS, MEDICAL DEVICES, OUR NATION'S FOOD SUPPLY, COSMETICS, AND PRODUCTS THAT EMIT RADIATION. THE FDA IS ALSO RESPONSIBLE FOR ADVANCING THE PUBLIC HEALTH BY HELPING TO SPEED INNOVATIONS THAT MAKE MEDICINES AND FOODS MORE EFFECTIVE, SAFER, AND MORE AFFORDABLE; AND HELPING THE PUBLIC GET THE ACCURATE, SCIENCE-BASED INFORMATION THEY NEED TO USE MEDICINES AND FOODS TO IMPROVE THEIR HEALTH.

CENTERS FOR DISEASE CONTROL AND PREVENTION

HEADQUARTERS: ATLANTA, GEORGIA

THE CDC IS THE LEAD FEDERAL AGENCY RESPONSIBLE FOR PROTECTING THE HEALTH OF THE AMERICAN PUBLIC THROUGH MONITORING OF DISEASE TRENDS, INVESTIGATION OF OUTBREAKS, HEALTH AND INJURY RISKS, FOSTER A SAFE AND HEALTHFUL ENVIRONMENTS, AND IMPLEMENTATION OF ILLNESS AND INJURY CONTROL AND PREVENTION INTERVENTIONS.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

HEADQUARTERS: ATLANTA, GEORGIA

ATSDR SERVES THE PUBLIC BY USING THE BEST SCIENCE, TAKING RESPONSIVE PUBLIC HEALTH ACTIONS, AND PROVIDING TRUSTED HEALTH INFORMATION TO PREVENT HARMFUL EXPOSURES AND DISEASES RELATED TO TOXIC SUBSTANCES.

INDIAN HEALTH SERVICE

HEADQUARTERS: ROCKVILLE, MD

THE IHS IS RESPONSIBLE FOR PROVIDING FEDERAL HEALTH SERVICES TO AMERICAN INDIANS AND ALASKA NATIVES. THE PROVISION OF HEALTH SERVICES TO MEMBERS OF FEDERALLY-RECOGNIZED TRIBES GREW OUT OF THE SPECIAL GOVERNMENT-TO-GOVERNMENT RELATIONSHIP BETWEEN THE FEDERAL GOVERNMENT AND INDIAN TRIBES. THE IHS IS THE PRINCIPAL FEDERAL HEALTH CARE PROVIDER AND HEALTH ADVOCATE FOR INDIAN PEOPLE, AND ITS GOAL IS TO RAISE THEIR HEALTH STATUS TO THE HIGHEST POSSIBLE LEVEL. THE IHS CURRENTLY PROVIDES HEALTH SERVICES TO APPROXIMATELY 1.5 MILLION AMERICAN INDIANS AND ALASKA NATIVES WHO BELONG TO MORE THAN 557 FEDERALLY RECOGNIZED TRIBES IN 35 STATES.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

HEADQUARTERS: ROCKVILLE, MD

HRSA PROVIDES ACCESS TO ESSENTIAL HEALTH SERVICES FOR PEOPLE WHO ARE POOR, UNINSURED, OR WHO LIVE IN RURAL AND URBAN NEIGHBORHOODS WHERE HEALTH CARE IS SCARCE. HRSA-FUNDED HEALTH CENTERS PROVIDE COMPREHENSIVE PRIMARY AND PREVENTIVE MEDICAL CARE AT MORE THAN 3000 SITES NATIONWIDE. WORKING IN PARTNERSHIP WITH MANY STATE AND COMMUNITY ORGANIZATIONS, HRSA ALSO SUPPORTS PROGRAMS THAT ENSURE HEALTHY MOTHERS AND CHILDREN, INCREASE THE

NUMBER AND DIVERSITY OF HEALTH CARE PROFESSIONALS IN UNDERSERVED COMMUNITIES, AND PROVIDE SUPPORTIVE SERVICES FOR PEOPLE INFECTED WITH HIV/AIDS. HRSA MANAGES THE NATIONAL PRACTITIONERS DATA BANK AND HEALTHCARE INTEGRITY AND PROTECTION DATA BANK.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

HEADQUARTERS: ROCKVILLE, MD

SAMHSA FUNDS AND ADMINISTERS A RICH PORTFOLIO OF GRANT PROGRAMS AND CONTRACTS THAT SUPPORT STATE AND COMMUNITY EFFORTS TO EXPAND AND ENHANCE PREVENTION AND EARLY INTERVENTION PROGRAMS AND TO IMPROVE THE QUALITY, AVAILABILITY AND RANGE OF SUBSTANCE ABUSE TREATMENT, MENTAL HEALTH AND RECOVERY SUPPORT SERVICES—IN LOCAL COMMUNITIES— WHERE PEOPLE CAN BE SERVED MOST EFFECTIVELY.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

HEADQUARTERS: ROCKVILLE, MD

AHRQ OPERATES RESEARCH CENTERS THAT SPECIALIZE IN MAJOR AREAS OF HEALTH CARE RESEARCH IN QUALITY IMPROVEMENT AND PATIENT SAFETY.OUTCOMES AND EFFECTIVENESS OF CARE; CLINICAL PRACTICE AND TECHNOLOGY ASSESSMENT; HEALTH CARE ORGANIZATION AND DELIVERY SYSTEMS; PRIMARY CARE (INCLUDING PREVENTIVE SERVICES).; AND HEALTH CARE COSTS AND SOURCES OF PAYMENT. AHRQ IS A MAJOR SOURCE OF FUNDING AND TECHNICAL ASSISTANCE FOR HEALTH SERVICES RESEARCH AND RESEARCH TRAINING AT LEADING U.S. UNIVERSITIES AND OTHER INSTITUTIONS.

HUMAN SERVICES OPERATING DIVISIONS

CENTERS FOR MEDICARE AND MEDICAID SERVICES

HEADQUARTERS: BALTIMORE, MD

CMS ADMINISTERS THE MEDICARE AND MEDICAID PROGRAMS, WHICH PROVIDE HEALTH CARE TO ABOUT ONE IN EVERY FOUR AMERICANS. MEDICARE PROVIDES HEALTH INSURANCE FOR MORE THAN 39 MILLION ELDERLY AND DISABLED AMERICANS. MEDICAID, A JOINT FEDERAL-STATE PROGRAM, PROVIDES HEALTH COVERAGE FOR MORE THAN 34 MILLION LOW-INCOME PERSONS, INCLUDING NEARLY 18 MILLION CHILDREN AND NURSING HOME COVERAGE FOR LOW-INCOME ELDERLY. CMS ALSO ADMINISTERS THE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) THROUGH APPROVED STATE PLANS.

ADMINISTRATION FOR CHILDREN AND FAMILIES

HEADQUARTERS: WASHINGTON, DC

ACF IS RESPONSIBLE FOR SOME 60 PROGRAMS THAT PROMOTE THE ECONOMIC AND SOCIAL WELL-BEING OF FAMILIES, CHILDREN, INDIVIDUALS AND COMMUNITIES. ADMINISTERS THE STATE-FEDERAL WELFARE PROGRAM, TEMPORARY ASSISTANCE TO NEEDY FAMILIES, the NATIONAL CHILD SUPPORT ENFORCEMENT SYSTEM, and THE HEAD START PROGRAM. ACF PROVIDES FUNDS TO ASSIST LOW-INCOME FAMILIES IN PAYING FOR CHILD CARE, AND SUPPORTS STATE PROGRAMS TO PROVIDE FOR FOSTER CARE AND ADOPTION ASSISTANCE. FUNDS PROGRAMS TO PREVENT CHILD ABUSE AND DOMESTIC VIOLENCE.

ADMINISTRATION ON AGING

HEADQUARTERS: WASHINGTON, DC

THE AOA MISSION IS TO DEVELOP A COMPREHENSIVE, COORDINATED AND COST-EFFECTIVE SYSTEM OF LONG-TERM CARE

THAT HELPS ELDERLY INDIVIDUALS TO MAINTAIN THEIR DIGNITY IN THEIR HOMES AND COMMUNITIES AS WELL AS TO HELP SOCIETY PREPARE FOR AN AGING POPULATION. AOA COORDINATES THE DELIVERY OF SUPPORTIVE SERVICES, PREVENTIVE HEALTH SERVICES, NUTRITION SERVICES, CAREGIVER SUPPORT, SUPPORT TO NATIVE AMERICANS, AND SERVICES THAT PROTECT THE RIGHTS OF VULNERABLE OLDER PERSONS, AS MANDATED BY THE OLDER AMERICANS ACT.

PROGRAM SUPPORT CENTER

HEADQUARTERS: ROCKVILLE, MD

PSC IS A SELF-SUPPORTING OPERATING DIVISION OF THE DEPARTMENT THAT PROVIDES ADMINISTRATION SERVICES FOR HHS AND OTHER FEDERAL AGENCIES.

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MEDICARE – AN OVERVIEW

BECAUSE A MAJORITY OF YOUR CALLS WILL INVOLVE THE MEDICARE PROGRAM IT WILL BE IMPORTANT FOR YOU TO HAVE A SOLID KNOWLEDGE OF MEDICARE'S STRUCTURE AND FUNCTION.

CREATED IN 1965, MEDICARE PROVIDES FEDERALLY SUBSIDIZED HEALTH INSURANCE TO OUR NATION'S SENIOR CITIZENS, TO PEOPLE WITH PERMANENT KIDNEY FAILURE, AND TO PEOPLE WITH DISABILITIES.

THE FEDERAL GOVERNMENT SPENDS HUNDREDS OF BILLIONS OF DOLLARS PER YEAR ON CLAIMS SUBMITTED BY PHYSICIANS, HOSPITALS, THERAPEUTIC CLINICS, HOME HEALTH COMPANIES, AND OTHER HEALTH CARE PROVIDERS FOR SERVICES RENDERED TO THE MORE THAN 40 MILLION MEDICARE BENEFICIARIES.

IN ITS ANNUAL REPORT TO CONGRESS, OIG IDENTIFIES BILLIONS OF MEDICARE DOLLARS THAT ARE MISSPENT ON ERRANT CLAIMS DUE TO FRAUD OR BILLING ERRORS.

GIVEN THE POPULARITY, SCOPE, AND CRITICAL MISSION OF MEDICARE, EFFORTS TO COMBAT FRAUD IN THE PROGRAM ARE GUARANTEED TO RECEIVE A GREAT DEAL OF ATTENTION FROM CONGRESS AND THE MEDIA.

MANY SENIOR CITIZENS FEEL ESPECIALLY PROTECTIVE OF MEDICARE AS "THEIR" PROGRAM AND CONSIDER IT THEIR DUTY TO REPORT INSTANCES OF SUSPECTED MEDICARE FRAUD.

PUBLIC EDUCATION CAMPAIGNS ON DETECTING MEDICARE FRAUD ROUTINELY SUGGEST CALLING OUR NUMBER— 1(800)HHS-TIPS.

NO ONE WILL EXPECT YOU TO UNDERSTAND EVERY DETAIL OF

MEDICARE OPERATIONS.

IN ORDER FOR YOU TO CARRY OUT YOUR RESPONSIBILITIES EFFECTIVELY, YOU WILL HAVE TO UNDERSTAND HOW MEDICARE WORKS BECAUSE —

- YOU WILL BE CALLED UPON TO ANSWER MANY SIMPLE QUESTIONS POSED BY MEDICARE BENEFICIARIES, AND
- IT WILL DAMAGE YOUR CREDIBILITY WITH THE CALLER IF YOU ARE NOT FAMILIAR WITH THE MEDICARE BASICS.

THE SOCIAL SECURITY ADMINISTRATION

MANY CALLERS UNDERSTANDABLY CONFUSE THE MEDICARE PROGRAM WITH SOCIAL SECURITY, THE OTHER MAJOR FEDERAL BENEFIT PROGRAM FOR SENIOR CITIZENS.

THE SOCIAL SECURITY ADMINISTRATION'S PRIMARY INVOLVEMENT WITH MEDICARE IS TO DETERMINE ELIGIBILITY FOR MEDICARE AND MAINTAIN A DATA BASE OF MEDICARE BENEFICIARIES.

ALL CITIZENS BECOME ELIGIBLE FOR MEDICARE AT AGE 65.

SOME MEDICARE BENEFICIARIES RECEIVE BENEFITS DUE TO DISABILITY OR PERMANENT KIDNEY FAILURE.

THE SOCIAL SECURITY ADMINISTRATION ALSO ISSUES MEDICARE CARDS, COLLECTS MEDICARE PART B PREMIUMS (SEE BELOW), AND PROCESSES ENROLLMENT IN PRIVATE MEDICARE PLANS.

THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, OR CMS (PRONOUNCED "SIMS") MANAGES THE MEDICARE PROGRAM AT THE FEDERAL LEVEL.

ON THE BASIS OF LAWS PASSED BY CONGRESS, CMS ESTABLISHES GENERAL POLICY FOR MEDICARE ON SUCH ISSUES AS WHAT SERVICES MEDICARE COVERS, WHAT DOCUMENTATION IS NECESSARY TO JUSTIFY MEDICARE PAYMENT, AND HOW MUCH MEDICARE PAYS FOR DIFFERENT SERVICES.

CMS IS NOT INVOLVED IN THE ACTUAL PROCESSING OR PAYMENT OF MEDICARE CLAIMS — THIS FUNCTION IS CONTRACTED OUT TO PRIVATE INSURANCE COMPANIES.

THROUGH ITS REGIONAL OFFICES, CMS MONITORS THE PERFORMANCE OF THESE CONTRACTORS.

TRADITIONAL MEDICARE (PARTS A AND B)

THE TRADITIONAL, OR "FEE-FOR-SERVICE," MEDICARE PROGRAM PAYS FOR SERVICES UNDER TWO DISTINCT CATEGORIES, PART A AND PART B.

PART A COVERS FACILITY CHARGES FOR INPATIENT HOSPITAL CARE AND FOR INPATIENT OR HOME REHABILITATION CONSIDERED INCIDENTAL TO A HOSPITAL STAY.

ALL LEGAL RESIDENTS WHO HAVE PAID MEDICARE TAXES FOR OVER TEN YEARS BECOME ELIGIBLE FOR MEDICARE PART A AT AGE 65.

PART A COVERS ALL EXPENSES FOR DEFINED BENEFIT PERIODS.

PART B IS THE SECOND COMPONENT OF THE TRADITIONAL "FEE-FOR-SERVICE" MEDICARE PROGRAM.

PART B COVERS PHYSICIAN SERVICES AND OUTPATIENT CARE AND SUPPLIES.

PART B IS VOLUNTARY; THE BENEFICIARY PAYS MONTHLY PREMIUMS.

THE BENEFICIARY OWES CO-INSURANCE FOR MOST PART B CLAIMS

CLICK HERE FOR A DETAILED LIST OF THE SERVICES COVERED BY TRADITIONAL MEDICARE.

CHARGES IN FEE FOR SERVICES MEDICARE ARE PROCESSED BY ENTITIES KNOWS AS MEDICARE ADMINISTRATIVE CONTRACTORS (MAC). THERE ARE 15 JURISDICTIONS FOR A/B MACS (THOSE WHICH PROCESS MOST PART A AND PART B CHARGES). THERE ARE ALSO SPECIALIZED MACS (WITH FEWER JURISDICTIONS) FOR DURABLE MEDICAL EQUIPMENT AND FOR HOME HEALTH/HOSPICE CHARGES. THE MACS REPLACED A PREVIOUS NETWORK OF CONTRACTORS KNOWN AS INTERMEDIARIES AND CARRIERS.

MEDICARE CLAIM CYCLE

THE BENEFICIARY RECEIVES TREATMENT FROM A PHYSICIAN.

AT THE TIME OF TREATMENT, THE PHYSICIAN MAKES NOTATIONS TO DOCUMENT THE SERVICES PERFORMED.

THE PHYSICIAN SUBMITS THESE NOTES TO A BILLING OFFICE, WHICH PREPARES THE MEDICARE CLAIM BY ENTERING THE APPROPRIATE CODES FOR BENEFICIARY'S CONDITION AND FOR THE SERVICES RENDERED.

THE CLAIM IS SUBMITTED TO THE APPROPRIATE MAC, USUALLY ELECTRONICALLY.

THE MEDICARE CARRIER WILL SUBJECT THE CLAIM TO VARIOUS COMPUTER EDITS IN ORDER TO DETERMINE —

- IS THE BENEFICIARY ELIGIBLE FOR MEDICARE BENEFITS?
- WAS THE SERVICE RENDERED?
- WAS THE SERVICE NECESSARY AND APPROPRIATE FOR THE

BENEFICIARY'S CONDITION?

- IS THE PROVIDER ELIGIBLE TO RECEIVE MEDICARE PAYMENTS?

BASED ON THE RESULTS OF THESE EDITS, THE CARRIER MAY —

- DENY THE CLAIM
- RETURN THE CLAIM TO THE PROVIDER FOR ADDITIONAL INFORMATION
- APPROVE THE CLAIM.

IF THE CONTRACTOR DECIDES THE CLAIM IS LEGITIMATE, IT WILL DETERMINE THE PAYMENT AMOUNT THAT CMS HAS ESTABLISHED FOR THE PARTICULAR SERVICE AND CALCULATE THE BENEFICIARIES COST SHARING.

WHETHER THE CARRIER APPROVES OR DISAPPROVES THE SERVICE, THE BENEFICIARY WILL RECEIVE A MEDICARE SUMMARY NOTICE REFLECTING THE CARRIER'S DECISION AND SHOWING HOW MUCH THE BENEFICIARY MAY BE BILLED FOR THE SERVICE.

MEDICARE SUMMARY NOTICE

WHENEVER A PROVIDER SUBMITS A CLAIM TO MEDICARE, AFTER THE CLAIM IS PROCESSED THE BENEFICIARY WILL RECEIVE A REPORT ON A QUARTERLY MEDICARE SUMMARY NOTICE (FREQUENCY MAY VARY BY REGION).

THE FORMAT OF THIS DOCUMENT WILL VARY SLIGHTLY ACCORDING TO THE TYPE OF CLAIM PROCESSED. ON ALL NOTICES THE BENEFICIARY WILL BE SHOWN WHAT SERVICE WAS PROVIDED AND HOW MUCH THE BENEFICIARY MAY BE BILLED AFTER MEDICARE PAYMENT.

IF THE CLAIM IS FOR PART A INPATIENT SERVICES, THE SUMMARY NOTICE WILL INDICATE THE NUMBER OF PART A BENEFIT DAYS

USED.

IF THE CLAIM IS FOR PART B OUTPATIENT FACILITY CLAIMS, THE SUMMARY NOTICE WILL INDICATE THE AMOUNT CHARGED, NON-COVERED CHARGES, AND CO-INSURANCE FOR EVERY SERVICE ITEM. (IF NON-COVERED CHARGES IS $0.00, IT MEANS THE INTERMEDIARY CONSIDERED THIS TO BE A LEGITIMATE CLAIM.)

IF THE CLAIM IS FOR PART B CHARGES FOR PHYSICIAN SERVICES OR DURABLE MEDICAL EQUIPMENT, THE SUMMARY NOTICE WILL INDICATE THE AMOUNT CHARGED, MEDICARE APPROVAL, AND CO-INSURANCE FOR EVERY SERVICE ITEM. (IF THE MEDICARE APPROVAL IS $0.00, IT MEANS THE MAC DID NOT APPROVE THIS CLAIM)

ALL MEDICARE SUMMARY NOTICES WILL SHOW THE AMOUNT OF THE CHARGES THAT THE BENEFICIARY IS RESPONSIBLE FOR PAYING IN A COLUMN "YOU MAY BE BILLED." (ALTHOUGH THE MEDICARE SUMMARY NOTICE IS NOT A BILL.)

THE SUMMARY NOTICE WILL PROVIDE THE PHONE NUMBER FOR MEDICARE (1-800-633-4227) WITH INSTRUCTIONS FOR HOW TO ASK FOR A REPRESENTATIVE TO DISCUSS THE CHARGES FROM THAT MSN.

IN ADDITION TO THE STANDARD INFORMATION, THE SUMMARY NOTICE MAY ALSO INCLUDE NOTES EXPLAINING HOW THAT PARTICULAR CLAIM WAS PROCESSED.

THE SUMMARY NOTICE ALSO PROVIDES INFORMATION ON HOW TO APPEAL A DECISION BY THE CONTRACTOR TO DENY A PARTICULAR CLAIM THAT THE BENEFICIARY FEELS SHOULD HAVE BEEN COVERED BY MEDICARE.

MANY BENEFICIARIES IN FEE-FOR-SERVICE MEDICARE ALSO CARRY SUPPLEMENTAL "MEDIGAP" INSURANCE TO COVER DEDUCTIBLES AND CO-INSURANCE (I.E., THE AMOUNT INDICATED IN THE "YOU MAY BE BILLED" COLUMN). FOR SOME SUPPLEMENTAL INSURERS, THE MEDICARE CONTRACTOR WILL AUTOMATICALLY NOTIFY THE

SUPPLEMENTAL INSURANCE WHEN IT PROCESSES A CHARGE. THE SUPPLEMENTAL INSURANCE WILL ALSO SEND A BENEFITS NOTICE, IN ADDITION TO THE MEDICARE SUMMARY NOTICE.

PRIVATE MEDICARE PLANS (PARTS C AND D)

MEDICARE ADVANTAGE PLANS (PART C)

THE OVERVIEW SO FAR HAS DESCRIBED FEE-FOR-SERVICE MEDICARE UNDER WHICH ELIGIBLE BENEFICIARIES MAY SEEK OUT CARE FROM ANY MEDICARE-PARTICIPATING PROVIDER.

AN INCREASING NUMBER OF MEDICARE BENEFICIARIES ARE OPTING TO RECEIVE THEIR SERVICES THROUGH PRIVATE MEDICARE PLANS, SOMETIMES REFERRED TO AS MEDICARE ADVANTAGE (MA) OR MEDICARE PART C PLANS.

THERE ARE A VARIETY OF PLAN TYPES BUT THEY FUNCTION IN SIMILAR WAYS:

- WHEN A BENEFICIARY CHOOSES TO ENROLL IN AN MA, CMS WILL PAY THE PLAN A PREARRANGED SUM TO PROVIDE ALL NECESSARY MEDICAL SERVICES FOR THE BENEFICIARY

- THE BENEFICIARY CONTINUES TO PAY PART B PREMIUMS (PLANS MAY CHARGE AN ADDITIONAL PREMIUM)

- MEDICARE ADVANTAGE PLANS ARE REQUIRED TO PROVIDE THE BENEFICIARY THE SAME LEVEL OF SERVICES AVAILABLE UNDER THE TRADITIONAL MEDICARE PROGRAM, BUT SOME PLANS OFFER ADDITIONAL BENEFITS, SUCH AS DENTAL OR VISION CARE

- THE PLAN IS RESPONSIBLE FOR PROCESSING AND PAYING CLAIMS, INCLUDING VERIFYING THAT SERVICES ARE BEING PROVIDED

- PRIVATE PLANS ARE LIMITED TO SPECIFIC GEOGRAPHIC

BOUNDARIES, AND PLANS MAY RESTRICT THE OVERALL NUMBER OF PARTICIPANTS.

ENROLLMENT INTO AND WITHDRAWAL FROM MANAGED CARE PLANS ARE PROCESSED BY THE SOCIAL SECURITY ADMINISTRATION.

MEDICARE PRESCRIPTION DRUG PLANS (PART D)

MEDICARE BENEFICIARIES ALSO HAVE THE OPTION OF CONTRACTING FOR PRESCRIPTION DRUG COVEREAGE. IN A STAND-ALONE PRESCRIPTION DRUG PLAN (PDP), THE BENEFICIARY REMAINS IN FEE-FOR-SERVICE MEDICARE FOR ALL PHYSICIAN CARE, HOSPITALIZATION, AND MEDICAL EQUIPMENT NEEDS.

THE PDP COVERS PRESCRIPTION DRUGS ONLY.

JUST AS WITH MA PLANS, PDP PLANS ARE LIMITED TO SPECIFIC GEOGRAPHIC BOUNDARIES.

EACH PDP HAS ITS OWN FORMULARY, A LIST OF MEDICATIONS THAT IT COVERS DIVIDED INTO TIERS, WITH MORE EXPENSIVE MEDICATIONS AT HIGHER TIERS.

THE BENEFICIARY'S RESPONSIBILITY FOR EACH PRESCRIPTION IS CALCULATED ACCORDING TO A COMPLEX FORMULA BASED ON THE BENEFICIARY'S TRUE OUT-OF-POCKET EXPENSES (TRooP):

- THE BENEFICIARY PAYS AN INITIAL DEDUCTIBLE;
- THEN THE PDP COVERS 75% OF COSTS UP TO THRESHHOLD SET BY MEDICARE;
- THEN THE BENEFICIARY IS RESPONSIBLE FOR ALL CHARGES UP TO ANOTHER THRESHHOLD SET BY MEDICARE (THIS GAP IS KNOWN AS THE "DOUGHNUT HOLE");
- THEN THE PDP PICKS UP ALL CHARGES.

IT IS THE BENEFICIARIES' RESPONSIBILITY TO REVIEW PLAN FORMULARIES BEFORE SELECTING A PLAN

SOME MEDICARE ADVANTAGE PLANS ALSO INCORPORATE PRESCRIPTION DRUG COVERAGE. THESE ARE KNOWN AS MA+PD PLANS. THE PRESCRIPTION DRUG PORTION OF THE PLAN WILL EMPLOY A DIFFERENT PAYMENT STRUCTURE. MA+PD PLANS ARE ALSO SUPPOSED TO MONITOR TRooP.

COMPANIES MARKETING MA+PD PLANS SHOULD MAKE CLEAR THAT ENROLLMENT WILL REMOVE THE BENEFICIARY FROM FEE-FOR-SERVICE MEDICARE. SIMILARLY, A PATIENT WHO IS ENROLLED IN AN MA PLAN WHO ENROLLS IN A STAND-ALONG PDP PLAN WILL BE RETURNED TO FEE-FOR-SERVICE MEDICARE FOR NON-PRESCRIPTION CARE.

MEDICARE AS SECONDARY PAYER

IN SOME INSTANCES, MEDICARE PAYS PROVIDERS ONLY AFTER OTHER PRIMARY INSURANCE HAS PAID ITS SHARE OF THE COSTS. THE THREE MAIN CATEGORIES ARE --

1) **WORKING BENEFICIARIES**: IF A MEDICARE BENEFICIARY IS STILL WORKING AT AGE 65 AND IS COVERED BY AN EMPLOYEE HEALTH PLAN, THEN MEDICARE WILL ONLY PAY AFTER THE GROUP HEALTH PLAN COVERS ITS SHARE. THIS APPLIES TO ALL HEALTH CARE COSTS INCURRED BY THE BENEFICIARY.

2) **WORKMAN'S COMPENSATION** RECIPIENTS: WORKMAN'S COMPENSATION IS AWARDED TO PEOPLE WHO SUFFER ON-THE-JOB INJURIES WHEN IT IS DETERMINED THE EMPLOYER WAS RESPONSIBLE FOR THE INJURIES. MANY WORKMAN'S COMPENSATION RECIPIENTS EVENTUALLY ARE DECLARED LEGALLY DISABLED BY THE SOCIAL SECURITY ADMINISTRATION, WHICH MAKES THEM ELIGIBLE FOR MEDICARE. FOR BENEFICIARIES IN THIS CATEGORY, MEDICARE WILL PAY AS SECONDARY PAYER FOR ANY MEDICAL CARE RELATED TO THE BENEFICIARY'S ON-THE-JOB INJURY –

THE EMPLOYER'S WORKMAN'S COMPENSATION INSURER IS THE PRIMARY PAYER FOR THESE SERVICES. FOR ALL MEDICAL CARE THAT IS **NOT** RELATED TO THE ON-THE-JOB INJURY, HOWEVER, MEDICARE IS THE PRIMARY PAYER.

3) **ACCIDENT VICTIMS:** FOR MEDICAL CARE RELATED TO INJURIES SUFFERED IN AN ACCIDENT, MEDICARE EXPECTS THAT THE BENEFICIARY WILL EXHAUST ALL AVAILABLE LIABILITY INSURANCE PAYMENTS BEFORE IT PAYS FOR SERVICES. THIS SHOULD NOT AFFECT THE BENEFICIARY'S MEDICARE COVERAGE FOR MEDICAL CARE **NOT** RELATED TO THE ACCIDENT.

THERE IS A SPECIAL MEDICARE CONTRACTOR SPECIFICALLY CHARGED WITH DETERMINING MEDICARE'S OBLIGATIONS WHEN MORE THAN ONE INSURANCE IS INVOLVED, THE COORDINATION OF BENEFITS CONTRACTOR (OR COOB).

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PROBLEM CALLERS

WHILE THE MAJORITY OF THE CALLS YOU HANDLE AT THE HOTLINE WILL PROCEED UNEVENTFULLY YOU NEED TO PREPARE FOR CERTAIN PROBLEM AREAS WHICH ARISE PERIODICALLY.

ANGRY CALLERS

IT IS INEVITABLE THAT WHILE WORKING AT THE CALL CENTER YOU WILL BE ENCOUNTER ANGRY CALLERS.

OF COURSE, IT IS UNFAIR THAT YOU BECOME THE TARGET OF A CALLER'S WRATH FOR REASONS ENTIRELY BEYOND YOUR CONTROL.

NONETHELESS YOU WILL HAVE TO WORK TO EASE THE TENSION BECAUSE YOU WILL HAVE TO DEAL WITH THE CALLER'S ANGER BEFORE YOU CAN CARRY OUT ANY MEANINGFUL EXCHANGE OF INFORMATION.

THE FIRST THING YOU NEED TO KEEP IN MIND IN DEALING WITH THE OCCASIONAL ANGRY CALL IS NOT TO TAKE IT PERSONALLY OR REACT IN KIND — LOWERING YOUR VOICE WILL GO MUCH FURTHER TOWARD REDUCING TENSIONS THAN WILL RAISING YOUR VOICE.

ALTHOUGH WE ALL HAVE OUR OWN SPECIAL TECHNIQUES FOR DEALING WITH CONFRONTATION, THE STRATEGY WE WOULD LIKE YOU TO KEEP IN MIND INVOLVES 4 STEPS:

1) IDENTIFY
2) ACKNOWLEDGE
3) EMPATHIZE
4) MOVE ON

THE FIRST STEP IN DEFUSING THE ANGER IS TO TRY TO **IDENTIFY** THE SOURCE OF THE EMOTION. UNDERSTANDING WHY THE CALLER IS ANGRY WILL NOT AUTOMATICALLY MAKE THE SITUATION LESS UNCOMFORTABLE, BUT IT WILL HELP YOU TO AVOID TAKING ANY HOSTILITY PERSONALLY.

ANY NATIONAL CALL CENTER, PARTICULARLY ONE DEALING WITH FRAUD ISSUES, IS DESTINED TO ATTRACT UNHAPPY PEOPLE FOR A VARIETY OF UNDERSTANDABLE REASONS:

- VICTIMIZATION: ANYONE WHO SUSPECTS THAT HE HAS BEEN TAKEN ADVANTAGE OF IS LIKELY TO FEEL EMBARRASSED AND VULNERABLE, THUS BE VERY EMOTIONAL.

- FRUSTRATION: A CALLER MAY HAVE DIALED SEVERAL NUMBERS BEFORE CALLING OURS AND IS TIRED OF THE "RUN-AROUND."

- SKEPTICISM: SOME OF OUR CALLERS HAVE GENERALLY DERISIVE VIEWS OF THE GOVERNMENT AND PUBLIC SERVANTS AND ARE LOOKING FOR EVIDENCE TO CONFIRM THEIR PREJUDICES.

- CONFUSION: FEW CALLERS WILL HAVE HAD ANY PREVIOUS EXPERIENCE WITH AN INSPECTOR GENERAL'S OFFICE, THUS THEY MIGHT HAVE DISTORTED OR EXAGGERATED VIEW OF OUR FUNCTION AND CAPABILITIES. UNFORTUNATELY, SUCH A CALLER MIGHT TAKE IT OUT ON YOU UPON LEARNING THAT YOU CANNOT PROVIDE THE IMMEDIATE ASSISTANCE.

- GUILT: YOU WILL RECEIVE CALLS FROM THE FAMILY MEMBERS OF MEDICARE BENEFICIARIES WHO ARE IN NURSING HOMES OR LIVE FAR AWAY. IF A CALLER SUSPECTS THAT SOMEONE HAS DEFRAUDED MEDICARE USING HIS BED-RIDDEN MOTHER'S ACCOUNT, THE

SITUATION IS LIABLE TO AROUSE GUILT ON HIS PART THAT HE IS NOT ABLE TO WATCH OVER HER AFFAIRS MORE CLOSELY.

WITHOUT BEING JUDGMENTAL, **ACKNOWLEDGE** THE CALLER'S ANGER: THIS CAN HELP TO BUILD TRUST — THE CALLER KNOWS THAT YOU ARE LISTENING! — AND MAY CHASTEN A CALLER WHO WAS UNAWARE THAT HER TONE WAS SO STRONG.

EXAMPLES:

WRONG: "MA'AM, YOU SHOULDN'T BE UPSET ABOUT THIS."

RIGHT: "I CAN TELL THAT YOU ARE UPSET ABOUT THIS."

THE NEXT STEP IS TO DISPLAY **EMPATHY** FOR WHATEVER IS BOTHERING THE CALLER SO GREATLY. IN DOING SO YOU SHOULD AVOID BEING PATRONIZING OR GROVELING.

EXAMPLES:

WRONG: "THERE, THERE. I'M SO SORRY FOR EVERYTHING YOU'VE BEEN THROUGH!"

RIGHT: "I KNOW HOW FRUSTRATING IT CAN BE WHEN YOU FEEL LIKE YOU ARE BEING SHUTTLED FROM ONE NUMBER TO ANOTHER."

BY THIS POINT, YOU HAVE HOPEFULLY GAINED ENOUGH CONFIDENCE FROM THE CALLER TO **MOVE ON** TO THE ISSUE AT HAND:

"LET'S SEE IF I CAN HELP YOU. GO AHEAD AND TELL ME ABOUT THE SITUATION."

HOPEFULLY, THE CALLER WILL STAY FOCUSED ON THE FRAUD ISSUE AND YOU CAN INTERVIEW HIM WITHOUT FEAR OF MORE EMOTIONAL BLOW-UPS.

ELDERLY CALLERS

THE SPECIAL NATURE OF THE INSPECTOR GENERAL'S HOTLINE, WITH ITS EMPHASIS ON THE MEDICARE PROGRAM, CALLS INTO PLAY A UNIQUE SET OF PROBLEMS. FOR EXAMPLE, THE PROTECTIVENESS THAT MANY SENIOR CITIZENS FEEL FOR THE MEDICARE PROGRAM ONLY INCREASES THE LEVEL OF VICTIMIZATION MENTIONED ABOVE. THERE ARE OTHER CAUSES OF ANGER WHICH WE CAN ASSOCIATE WITH THE MEDICARE BENEFICIARY POPULATION:

- COGNITIVE DIFFICULTIES: SADLY, MANY OF OUR ELDERLY CALLERS WILL SUFFER FROM HEARING PROBLEMS, SHORT-TERM MEMORY LOSS, OR PERHAPS EVEN EARLY STAGES OF DEMENTIA. IN ADDITION TO HAVING TROUBLE COMMUNICATING, SUCH A CALLER CAN PLACE A HEAVY EMOTIONAL BURDEN ON YOU.

- FEAR: WE SHOULD NOT UNDERESTIMATE THE SENSE OF VULNERABILITY THAT MANY OF OUR CALLERS EXPERIENCE. ANY SUCH CALLER MAY CHOOSE TO DEAL WITH THEIR FEAR BY LASHING OUT AT YOU.

- PAIN: ANYONE TENDS TO BE MORE IRASCIBLE WHEN IN PAIN DUE TO AN ILLNESS OR INJURY. MANY OF OUR ELDERLY CALLERS EXPERIENCE CHRONIC PAIN WITH LITTLE HOPE OF ANY RELIEF. SOME MAY BE IN THE FINAL STAGES OF DEBILITATING ILLNESSES. THIS MAY ACCOUNT FOR THE SUDDEN FLASH OF ANGER DISPLAYED BY AN ELDERLY CALLER WHO HAD SEEMED PLEASANT AT THE START OF THE CONVERSATION.

AT ALL TIMES YOU SHOULD STRIVE TO TREAT ELDERLY CALLERS WITH THE DIGNITY AND RESPECT THEY DESERVE: JUST BECAUSE YOU NEED TO SPEAK LOUDER OR REPEAT SOME WORDS TO A CALLER DOES NOT MEAN THAT YOU SHOULD ADDRESS HIM AS A CHILD.

URGENT PERSONAL SITUATIONS

THE SOURCE OF CONTENTION IN MANY CALLS WILL BE THAT THE CALLER IS TRYING TO RESOLVE AN URGENT PROBLEM, SUCH AS RECEIVING NECESSARY MEDICAL ATTENTION, QUALIFYING FOR SOCIAL SERVICES, OR SEEKING RELIEF FROM A COLLECTION AGENCY. THE CALLER WILL TURN TO THE OIG IN DESPERATION, WITH AN EXPECTATION THAT WE HAVE SOME CLUB WE CAN WIELD TO FORCE THE LOCAL AGENCY OR HEALTHCARE PROVIDER TO ACQUIESCE TO THE CALLER'S WISHES.

SUCH CALLERS MISTAKE THE OIG FOR AN OMBUDSMAN OR CONSUMER HELP LINE. IN THE OMBUDSMAN MODEL, THE CALL CENTER REPRESENTATIVE WOULD TAKE RESPONSIBILITY FOR THE CALLER'S CASE. THE REPRESENTATIVE WOULD STAY IN FREQUENT CONTACT WITH THE CALLER, KEEPING HIM INFORMED OF WHAT STEPS ARE BEING TAKEN TO TRY TO RESOLVE THE CALLER'S PROBLEM. CLEARLY, THIS IS NOT HOW WE OPERATE.

WHEN CONFRONTED WITH A SITUATION LIKE THIS DO NOT JUST SAY "WE DON'T DO THAT" OR "WE CAN'T HELP YOU" AND LEAVE IT AT THAT. YOU SHOULD COUCH YOUR EXPLANATION IN TERMS OF THE OIG MISSION. THE OIG PRIMARY GOAL IS TO IDENTIFY SYSTEMIC ISSUES AND PROBLEMS, AS WELL AS EVALUATING INDIVIDUAL COMPLAINTS TO DETERMINE IF FURTHER INVESTIGATION IS WARRANTED. [IT IS TELLING THAT THE OIG EMPLOYS MORE AUDITORS THAN IT DOES AGENTS.] IN OTHER WORDS, IT IS HIGHLY IMPROBABLE THAT OIG WILL ASSUME RESPONSIBILITY FOR RESOLVING AN INDIVIDUAL ISSUE BECAUSE OF ITS COMPELLING EMOTIONAL PULL. MORE TIMES THAN NOT, THE ONLY OFFICE THAT MIGHT BE ABLE TO PROVIDE SOME HELP WILL BE AT THE STATE OR LOCAL LEVEL.

DO NOT BE INTIMIDATED BY STATEMENTS OF THE TYPE "THEY TOLD ME AT MEDICARE [OR ANY OTHER OFFICE] THAT YOU COULD HELP ME." SO WHILE ACKNOWLEDGING THE SERIOUSNESS OF A GIVEN SITUATION, DO NOT SHY FROM TELLING THE CALLER, POLITELY, "I'M AFRAID YOU WERE MISINFORMED ABOUT WHAT OUR OFFICE CAN

DO."

AS MUCH AS WE WANT YOU TO BE HELPFUL AND EMPATHETIC, YOU MUST MAINTAIN SOME EMOTIONAL DISTANCE AT THE SAME TIME: IN THE COURSE OF YOUR JOB YOU WILL SPEAK WITH SOME VERY NEEDY CALLERS WHO YOU WILL BE UNABLE TO ASSIST, NO MATTER HOW HEARTRENDING THEIR SITUATIONS.

ALONG THE SAME LINES, TRY NOT TO ALLOW YOUR NATURAL INCLINATION TO BE HELPFUL TO CAUSE YOU TO MAKE COMMITMENTS YOU ARE UNABLE TO FULFILL. IF THERE IS AN INDICATION THAT SOMEONE HAS VIOLATED THE GUIDELINES FOR MEDICARE, OR ANY OTHER DEPARTMENT PROGRAM, GO AHEAD AND ENTER A COMPLAINT, BUT YOU SHOULD NOT GIVE THE CALLER ANY INDICATION THAT IT WILL RECEIVE ANY SPECIAL TREATMENT. THAT IS, DO NOT PROMISE THAT SOMEONE WILL CONTACT THE COMPLAINANT, DO NOT PROMISE ANY EXPEDITED TREATMENT.

MALICIOUS CALLERS

ALTHOUGH IT IS YOUR RESPONSIBILITY TO TRY DEAL AS BEST AS YOU CAN WITH AN ANGRY CALLER, YOU NEED TO DISTINGUISH BETWEEN AN ANGRY CALLER AND A MALICIOUS CALLER.

NO ONE EXPECTS YOU TO TOLERATE ABUSIVE BEHAVIOR.

IF A CALLER ENGAGES IN ABUSIVE BEHAVIOR, SUCH AS —

- RACIAL OR SEXUAL SLURS
- PROFANITY
- PERSONAL ATTACKS (E.G., "YOU IDIOT")

OR SIMPLY IS TOO ENRAGED TO CONDUCT A RATIONAL CONVERSATION, YOU SHOULD TERMINATE THE CALL.

IF THIS HAPPENS, TRY TO INFORM A SUPERVISOR ABOUT THE INCIDENT. AT A MINIMUM, DOCUMENT THE INCIDENT IN YOUR OWN RECORD, NOTING TIME, DATE, AND GENERAL INFORMATION ABOUT THE CALL.

IRRATIONAL CALLERS

IN A RELATED SUBJECT, YOU WILL PERIODICALLY RECEIVE CALLS FROM PEOPLE SUFFERING FROM DELUSIONAL AND OBSESSIVE BEHAVIOR. A SEEMINGLY ROUTINE CONVERSATION MAY SUDDENLY VEER OFF ONTO BIZARRE SUBJECTS LIKE EXTRA-TERRESTRIAL ACTIVITY, MICROCHIP IMPLANTS, OR CIA SURVEILLANCE.

YOU MAY FIND THESE CALLS ANNOYING, BUT YOU SHOULD TRY TO MAINTAIN A RESPECTFUL TONE.

OF COURSE, THIS DOES NOT MEAN THAT YOU SHOULD ENTER A COMPLAINT AGAINST THE CIA FOR CONTROLLING SOMEONE'S MOVEMENTS, ONLY THAT YOU SHOULD TRY TO MAKE THE CALLER FEEL LIKE YOU LISTENED TO THEIR PROBLEM.

THREATS

YOU SHOULD REPORT ANY SERIOUS THREATS OF VIOLENCE TO YOUR SUPERVISOR **IMMEDIATELY** — TRY TO NOTE AS MANY SPECIFIC DETAILS FROM THE CONVERSATION AS POSSIBLE.

TERMINATING CALLS

THERE ARE GOING TO BE MANY INSTANCES WHEN CALLERS TEST YOUR PATIENCE WITHOUT MEETING THE THRESHOLDS SET FORTH ABOVE FOR MALICIOUS OR IRRATIONAL CALLERS. THIS MIGHT BE

- A PERSISTENT CALLER WHO INSISTS THAT THE OIG SHOULD INVESTIGATE A COMPLAINT THAT WOULD BE OUTSIDE OUR JURISDICTION;

- A CALLER WHO HAS NUMEROUS QUESTIONS ABOUT THE DEPARTMENT, OIG, OR THE HOTLINE; OR

- A COMPLAINANT WHO WANTS TO REITERATE INFORMATION THAT YOU HAVE ALREADY COVERED.

YOU MAY TERMINATE SUCH CALLS, BUT ONLY AFTER YOU HAVE EXHAUSTED ALL POSSIBLE EFFORTS TO EXPLAIN TO THE CALLER THAT THE SITUATION IS NOT APPROPRIATE FOR OIG OR THAT YOU CAN PROVIDE NO FURTHER ASSISTANCE.

WITH A NON-MALICIOUS CALLER TERMINATING THE CALL SHOULD BE A LAST RESORT; IT SHOULD NEVER OCCUR ABRUPTLY: YOU SHOULD GIVE THE CALLER A GENTLE WARNING THAT CONVEYS THE MESSAGE THAT YOU NEED TO BE AVAILABLE TO ASSIST OTHER CALLERS – AND NOT THAT YOU ARE BOTHERED BY THE CALLER.

YOU SHOULD IMMEDIATELY DOCUMENT ANY INSTANCE WHEN YOU TERMINATE A CALL TO INCLUDE AT A MINIMUM THE TIME AND DATE, ALONG WITH A FEW WORDS TO PROMPT YOUR MEMORY ABOUT THE CALL.

WHEN ASKED ABOUT A CALL YOU HAD TO TERMINATE IT IS **NEVER ACCEPTABLE** TO SAY THAT YOU FORGOT THE REASON.

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